HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
JANUARY 22, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	MUA of Middle Tennessee, LLC
PROJECT NUMBER:	CN1308-031
ADDRESS:	28 White Bridge Road, Suite #210 Nashville (Davidson County), Tennessee 37205
LEGAL OWNER:	MUA of Middle Tennessee, LLC 28 White Bridge Road Nashville (Davidson County), Tennessee 37205
OPERATING ENTITY:	Not Applicable
CONTACT PERSON:	E. Graham Baker, Jr. (615) 370-3380
DATE FILED:	August 15, 2013
PROJECT COST:	$113,000.00
FINANCING:	Cash Reserves
PURPOSE OF REVIEW:	The addition of interventional pain management services to a single specialty ambulatory surgical treatment center (ASTC) with one (1) procedure room

DESCRIPTION:

MUA of Middle Tennessee, LLC is seeking approval for the addition of interventional pain management services to its existing one operating room single specialty ambulatory surgical treatment center (ASTC) that currently only provides manipulation under anesthesia (MUA) procedures.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

Ambulatory Surgical Treatment Centers (*Revised May 23, 2013*)

The following apply:

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need.[2] An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

   The applicant is projecting 3,455 cases in Year One (2014) and 4,442 cases in Year Two (2015). The projected cases will be limited to pain management intervention procedures.

   It appears this criterion has been met.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

   Based on an average of 15 minutes per case, the projected surgical hours will be 16.6 hours per week or 864 hours in Year One and 21.3 hours per week or 1,111 hours in Year Two.

It appears this criterion has been met.

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available[3]) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

   The applicant has provided a utilization table of all pain management ASTCs in the proposed service area for 2010, 2011 and 2012. The tables are located in attachment C.N.5.A. and C.N.5.B. of the application.

   It appears this criterion has been met.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

   There are a total of four (4) single-specialty pain management ASTCs in the proposed service area representing a total of three (3) ORs and eight (8) procedure rooms in 2012. For purposes of this review, it is typical for single specialty pain management ASTCs to use only non-sterile procedure rooms. HSDA staff contacted two (2) of the four (4) single specialty pain management ASTCs representing the three (3) ORs and verified the three (3) ORs are being used as procedure rooms. The four (4) single-specialty pain management ASTCs provided 7,766 cases in 2012. Single specialty pain management ASTCs in the service area were utilized at 38% in 2012 when using 1867 cases per procedure room as the baseline numbers for purposes of determining need. There are a total

of ten (10) multi-specialty ASTCs performing pain management in the service area representing a total of fifty-four (54) ORs and eleven (11) procedure rooms. The ten (10) multi-specialty ASTCs provided 8,007 pain management surgical cases representing 13.8% of overall surgical procedures in 2012 for multi-specialty ASTCs providing pain management services. HSDA staff could not calculate current pain service area utilization using 1867 Cases per Procedure Room as the baseline numbers for purposes of determining need at 70% utilization or above. Procedure room and operating room utilization are reported together on ASTC Joint Annual reports and all the multi-specialty ASTCs have both operating and procedure rooms.

Even though service capacity cannot be determined for the multi-specialty ASTCs, since the single specialty pain management ASTCs are not meeting the 70% standard, it appears this criterion has not been met.

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

3,455 cases are projected in Year One and 4,442 cases in Year Two. All cases will be performed in a procedure room. Single specialty pain management ASTCs in the service area were utilized at 38% in 2012 when using 1867 cases per procedure room as the baseline numbers for purposes of determining Need. HSDA staff was unable to calculate current pain service area utilization using 1867 Cases per Procedure Room as the baseline numbers for purposes of determining need at 70% utilization or above for the multi-specialty ASTCs that provide pain management services. Procedure room and operating room utilization are inclusive on ASTC Joint Annual reports and are not individually reported and all the multi-specialty ASTCs have operating and procedure rooms.

Even though service capacity cannot be determined for the multi-specialty ASTCs, since the single specialty pain management ASTCs are not meeting the 70% standard, it appears this criterion has not been met.

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

   The majority of patients reside within 60 minutes of the facility.

   It appears this criterion has been met.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available

   Metro-Davidson county public transportation is available.

   It appears this criterion has been met.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

   98% of patients will originate from Davidson, Williamson, Rutherford and Robertson counties.

   It appears this criterion has been met.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for

each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Projected utilization ranges from 863 cases in the first quarter to 1,111 cases in the eighth quarter.

It appears this criterion has been met.

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant is certified by both Medicare and Medicaid, and is accredited by AAAHC.

It appears this criterion has been met.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

Jay Parekh, DO, Anesthesiologist, Board Certified in Pain Medicine will provide pain intervention services.

It appears this criterion has been met.

11 Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as

designated by the United States Health Resources and Services Administration;

There are three (3) medically underserved designated areas in Davidson County, one (1) in Williamson County, one (1) in Robertson County, and one (1) in Rutherford County.

It appears this criterion has been met.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Since the applicant is not a hospital, this standard is not applicable to this proposed project.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

The applicant facility is Medicare and Medicaid certified. The applicant stated in the first supplemental response that the ASTC has a contract with Amerigroup to provide interventional pain procedures and is currently in contract negotiations with Americhoice.

It appears this criterion has been met.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard

Not applicable. The proposed pain invention procedures will average 15 minutes.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

The applicant, MUA of Middle Tennessee, LLC (CN1009-045A), was originally approved at the December 15, 2010 Agency meeting for the establishment of a single-specialty one procedure room ambulatory treatment center (ASTC) providing only manipulation under anesthesia (MUA) services with no actual operative surgical procedures being performed. The applicant now proposes to add interventional pain management services to its existing ASTC by using the same one procedure room that is currently licensed for MUA services. MUA procedures and interventional pain procedures will not be performed at the same time on the same patient.

The applicant indicates MUA of Middle Tennessee, LLC is forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. MUA involves relaxing the patient with anesthesia, and making manual corrections to biomechanical abnormalities by stretching and manipulation. The goal of MUA is to increase the patient's range of motion and/or relief of pain, improve functional capacity, and reduce narcotic use in the treatment of pain.

In the supplemental response, the applicant indicates the ASTC will be performing services for the patients of Tennessee Spine and Nerve also located in the Anderson Building in Suite 208, 28 White Bridge Road, Nashville, TN. Tennessee Spine and Nerve is a Tennessee registered licensed pain clinic. The applicant, MUA of Middle Tennessee, LLC is also located in Suite 210 in the Anderson Building. According the Tennessee Spine and Nerve Institute's website the following procedures are offered on-site: Dorsai Column Stimulation, Epidural Steroid Injection, Facet Injections, Lumbar Radiofrequency Ablation, Peripheral Nerve Stim Trials, Trigger Point Injections and Ultrasound Guided Injections.

In addition, the Tennessee Spine and Nerve Institute's also operates White Bridge Family Practice located in Suite 209 in the Anderson Building. *Source: http://tnspineandnerve.com/white-bridge-family-practice*.

An overview of the project is provided on pages 8-9 of the original application.

Project History

Note to Agency members: The following is a timeline of events that led to the filing of this application:

- *December 2010-CN1009-045A, MUA of Middle Tennessee, LLC was approved by the Agency to establish a single specialty ambulatory surgical treatment center (ASTC) limited to manipulation under anesthesia.*
- *October 2011-Upon completion of the ASTC, the applicant requested a staff determination as to whether Manipulation Under Joint Anesthesia [MUJA] is part of the MUA services.*
- *November 2011-A staff determination was issued that MUJA is part of the MUA services permitted under CN1009-045A.*
- *November 2012-Concern arose about whether the determination had been correct. HSDA staff contacted the Tennessee Department of Health (TDH) for assistance in getting the right answer to this medically complex question; TDH's Medical Director of the Board of Medical Examiners, who is also the Chairman of the Board for Licensing Health Care Facilities, recommended that HSDA staff withdraw the staff determination.*
- *December 2012-The TDH's Medical Director of the Board of Medical Examiners recommendation led to HSDA staff's issuance of a determination that a separate CON would be needed to add pain management procedures for MUJA to be performed at the applicant's ASTC.*
- *March 2013-After several months of dialogue with interested parties and staff's consultation with the HSDA Chair, it was decided that the questions should be decided by the HSDA itself after hearing from all sides in a public forum. It was also decided that until the HSDA adopts a position on this, staff would take no position; therefore, all staff determinations were rescinded.*
- *August 2013-Rather than receive an Agency Determination, the applicant chose to file this application for the addition of pain management services. Therefore, whether MUJA has already been authorized is not an issue in whether to approve this application.*

Ownership

MUA of Middle Tennessee, LLC is a Tennessee registered limited liability company (LLC) formed September 15, 2010. MUA of Middle Tennessee, LLC is owned and managed by five (5) members: Robert Odell, M.D. (39%), Lance C. Benedict, DC (21.5%), Terry Totty, DC (21.5%), Paul Yim, MD (12%), and Michael Goorevich (6%).

Drs. Terry Totty and Lance Benedict, who have ownership interests in MUA of Middle Tennessee, also own Tennessee Spine and Nerve Institute.

Facility Information

- MUA of Middle Tennessee, LLC subleases 1,493 square feet of floor space on the second floor of an existing office building located at 28 White Bridge Road, Suite 210, Nashville (Davidson County), Tennessee 37205, from the Tennessee Spine and Nerve Institute, Inc., which currently leases from NOL, LLC.
- A floor plan drawing is included in Attachment B.IV. – Floor Plan.

Equipment

There is no major medical equipment involved with this project. The applicant will use an existing Fluoroscopy C-Arm. A certificate of need is not required for this equipment since the cost is under $2,000,000.

Service Area Demographics

MUA of Middle Tennessee's declared primary service area is Davidson, Williamson, Rutherford, and Robertson counties.

- The total population of the service area is estimated at 1,125,193 residents in calendar year (CY) 2013 increasing by approximately 2.6% to 1,179,087 residents in CY 2017.
- The overall statewide population is projected to grow by 3.7% from 2013 to 2017.
- The latest 2013 percentage of the proposed service area population enrolled in the TennCare program is approximately 15.7%, as compared to the statewide enrollment proportion of 18.8%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Service Area Historical Utilization

The utilization table below reflects the following for single-specialty ASTCs limited to pain management.

- In 2012 there were four (4) single specialty ASTCs providing pain management services.
- 15.6% increase in total single-specialty pain management ASTC surgeries cases in the service area from 6,714 in 2010 to 7,766 in 2012.

- Crossroads Surgery Center in Williamson County experienced the largest pain management case percentage increase of 96.4% from 220 cases in 2010 to 432 cases in 2012, but represented the smallest percentage of cases (5.5%) overall.

Historical Capacity and Utilization of Single-Specialty Pain Management ASTSs within 4 Co. Service Area

			2010 (Final)	2011 (Final)	2012 (Final)	
County	**ASTC**	**Oper. Rms/ Proc. Rms**	**Cases**	**Cases**	**Cases**	**% change 10'-12'**
Davidson	Premier Radiology Pain Management (Single Specialty)	0/2				
	Total Outpatient Surgery Cases		**1,666**	**2,000**	**1,957**	**+17.5%**
Davidson	St. Thomas Outpatient Neurosurgical Ctr.	2/1				
	Total Outpatient Surgery Cases		**2,523**	**2,469**	**2,530**	**+.27%**
Davidson	Tennessee Pain Surgery Ctr.	1/3				
	Total Outpatient Surgery Cases		**2,305**	**3,316**	**2,847**	**+24%**
Williamson	Crossroads Surgery Ctr.	0/2				
	Total Outpatient Surgery Cases		**220**	**275**	**432**	**+96.4%**
	Service Area Totals	3/ 8 = 11				
	OR/PR		3/8=11	3/7=10	3/8=11	n/a
	Total Pain Management Surgery Cases		6,714	8,060	7,766	+15.6%
	Cases per OR/PR		610	806	706	+15.7

Historical Capacity and Utilization of Multi-Specialty ASTSs within 4 Co. Service Area

			2010 (Final)	2011 (Final)	2012 (Final)		
County	ASTC	OR. Rms/ Proc. Rms	Cases	Cases	Cases	PM % of Total	% change 10'-12'
Davidson	Baptist Ambulatory Surgery Center	6/1					
	Pain Management		1,077	1,098	1,178	15.8%	+9.4%%
	Total Outpatient Cases		**7,472**	**7,304**	**7,443**		**-.40%**
Davidson	Baptist Plaza Surgicare	9/1					
	Pain Management		942	568	340	4.1%	-64%
	Total Outpatient Cases		**9,427**	**9,171**	**8,215**		**+12.9%**
Davidson	Centennial Surgery Center	6/2					
	Pain Management		1,116	1,556	1,569	20.9%	40.6%
	Total Outpatient Cases		**7,217**	**7,405**	**7,491**		**+3.8%**
Davidson	Northridge Surgery Center	5/2					
	Pain Management		654	273	296	10.3%	-54.8%
	Total Outpatient Cases		**3,673**	**3,201**	**2,863**		**-22%**
Davidson	Premier Orthopaedic Surgery Center	2/0					
	Pain Management		681	974	143	6.3%	-79%
	Total Outpatient Cases		**2,104**	**2,382**	**2,277**		**+8.2%**
Davidson	St. Thomas Campus Surgicare	6/1					
	Pain Management		1,459	1,721	1,624	21.8%	+11.3%
	Total Outpatient Cases		**6,835**	**7,639**	**7,446**		**+8.9%**
Davidson	Summit Surgery Center	5/1					
	Pain Management		2,267	1,672	1,057	16.4%	-53.4%
	Total Outpatient Cases		**6,873**	**6,505**	**5,445**		**-20.7%**
Rutherford	Middle Tennessee ASTC	6/1					
	Pain Management		437	464	597	9.2%	+36.6%
	Total Outpatient Cases		**6,244**	**6,264**	**6,490**		**+4.0%**
Rutherford	Physicians Pavilion Surgery Center	4/1					
	Pain Management		922	752	833	29%	-9.6%
	Total Outpatient Cases		**3,243**	**2,976**	**2,864**		**-11.7%**
Rutherford	*Surgicenter of Murfreesboro Medical Clinic	4/3					
	Pain Management		9				
	Total Outpatient Cases		**7,468**				
Williamson	ASTC of Cool Springs	5/1					
	Pain Management		233	12	370	50.7%	+58.8%
	Total Outpatient Cases		**6,790**	**6,501**	**7,292**		**+7.3%**
Williamson	**Williamson Surgery Center	4/1					
	Pain Management		1	6			
	Total Outpatient Cases		**3,531**	**3,410**			
	Service Area Totals						
	OR/PR		61/14=75	57/12=69	54/11=65		-13.3%
	Pain Management		9,788	9,096	8,007	13.8%	-18.2%
	Total Outpatient Cases		**70,877**	**62,759**	**57,826**		**-18.4%**
	Cases per OR/PR		945	910	890		-5.8%

Source: Tennessee Department of Health, Division of Health Statistics, Joint Annual Reports

**Surgicenter of Murfreesboro Medical Clinic continues to operate as an ASTC but did not provide pain management services in 2011 and 2012. Source: TDH Joint Annual Reports*

***In August 2011 Williamson Medical Center purchased additional ownership in Williamson Surgery Center and began consolidating with the surgery center.*
Source: http://www.comptroller.tn.gov/repository/CA/2011/williamson.pdf

The utilization table on the preceding page reflects the following for multi-specialty ASTCs performing pain management services:

- In 2012 there were ten (10) multi-specialty ASTCs in the service area providing pain management services
- Total multi-surgery pain management surgical cases decreased 18.2% from 9,788 in 2010 to 8,007 in 2012.
- The total number of ORs/PRs decreased 13.3% from 75 in 2010 to 65 in 2012. This is mainly due to Surgicenter of Murfreesboro not providing pain management service in 2011 and 2012, and Williamson Surgery Center becoming part of Williamson Medical Center.
- 5.8% decrease overall in cases per OR/PR in multi-specialty ASTCs from 945 in 2010 to 890 in 2012.

Project Cost
Major costs are:

- Legal, Administrative (Excluding CON Filing Fee), Consultant- $50,000, or 44.2% of cost.
- Moveable Equipment- $60,000, or 53.1% of the total cost.
- For other details on Project Cost, see the Project Cost Chart on page 23 of the application.

There are no renovation or construction costs. Facility costs were approved when the original ASTC was approved on December 15, 2010 in CN1009-045A.

Financing
All costs associated with this project are administrative only, and have already been paid through cash reserves.

Historical Data Chart
The applicant did not provide a historical data chart because there was not sufficient historical utilization at the time HSDA staff determined that a separate CON would be required for pain management services.

Projected Data Chart
The applicant projects $4,646,975.00 in total gross revenue on 3,455 cases during the first year of operation and $5,974,490 on 4,442 cases in Year Two (approximately $1,345 per case). The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal $130,600 in Year One increasing to $339,552 in Year Two.
- Net operating revenue after bad debt, charity care, and contractual adjustments is expected to reach $1,194,900 or approximately 20% of total gross revenue in Year Two.
- Charity care at approximately 5.0% of total gross revenue in Year One and 5.0% in Year Two equaling to $232,348 and $298,724, respectively.
- Charity Care calculates to 173 cases in Year One and 222 cases in Year Two.
- In the supplemental response, the applicant provided a Projected Data Chart for the total facility which projects $6,896,975 in total gross revenue on 3,605 cases during the first year of operation and $8,749,490 on 4,627 cases in Year Two.

Charges

In Year One of the proposed project, the average pain management charges are as follows:

- The proposed average gross charge is $1,345/case in 2014.
- The average deduction is $1,076/case, producing an average charge of $269/procedure.

Medicare/TennCare Payor Mix

- TennCare- Charges will equal $464,698 in Year One representing 10% of total gross revenue.
- Medicare- Charges will equal $1,858,790 in Year One representing 40% of total gross revenue.

Staffing

No additional staff is required for the addition of pain management services of MUA of Middle Tennessee, LLC. The applicant's proposes to share the following existing ASTC direct patient care staff in Year One:

- One (1) FTE Registered Nurse and
- One (1) FTE Radiology Tech

Licensure/Accreditation

MUA of Middle Tennessee, LLC is licensed as an ASTC by the Tennessee Department of Health, Division of Health Care Facilities. A letter dated March 6, 2012 from the Tennessee Department of Health indicated the facility to be in compliance in all areas as a result of an on-site initial state licensure inspection completed on February 7, 2012.

MUA of Middle Tennessee, LLC is accredited by the Accreditation Association for Ambulatory Health Care for a three year period which expires on August 7, 2015.

Corporate documentation, real estate lease, and detailed demographic information are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in **two** years. The applicant seeks to open the ASTC in January 2014.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied or pending applications for other health care organizations in the service area proposing this type of service.

Outstanding Certificates of Need

Baptist Plaza Surgicare, CN1307-029A, has an outstanding Certificate of Need which will expire on December 1, 2015. The CON was approved at the October 23, 2013 Agency meeting for relocation and replacement of the existing ASTC from 2011 Church Street, Medical Plaza I Lower Level, Nashville (Davidson County), to the northeast corner of the intersection of Church Street and 20th Avenue North, Nashville (Davidson County). The facility will be constructed in approximately 28,500 square feet of rentable space in a new medical office building and will contain nine (9) operating rooms and one (1) procedure room. The estimated project cost was **$29,836,377.00** *Project Status: Recently approved.*

Interventional Pain Physicians Surgery Center, CN1201-001A, has an outstanding Certificate of Need which will expire on June 1, 2014. The CON was approved at the April 25, 2012 Agency meeting for the establishment of an single-specialty ASTC limited to pain management with one (1) surgical procedure room in a medical office building establishment of a single-specialty ambulatory surgical treatment center (ASTC) in a medical office building in Smyrna (Rutherford County). The estimated project cost was **$844,622.00.** *Project Status: A representative of the applicant reported in a 1/10/14 email that the ASTC is 90% constructed and expects to be licensed and operating in mid-April.*

Franklin Endoscopy Center, CN1209-046A, has an outstanding Certificate of Need which will expire on February 1, 2015. The CON was approved at the December 12, 2012 Agency meeting for the relocation of existing ASTC with two (2) surgical procedure suites for endoscopic procedures and the addition of two (2) multi-specialty outpatient surgery operating rooms and related support space for credentialed open medical staff-converting single to multi-specialty. The estimated project cost was **$7,420,105.00.** *Project Status: A 1/9/14 email from a representative of the applicant stated that the surgery center is about 20% complete. Framing is in place, core drilling for mechanical, plumbing, and electric (MPE) complete and MPE rough-ins in progress. Next step will be rough-in inspections. The expected completion date is May 2014.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME
1/6/2013

LETTER OF INTENT

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LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the *Tennessean* which is a newspaper of general
(Name of Newspaper)

circulation in Davidson County, Tennessee, on or before August 10, 2013 for one day.
(County) (Month / day) (Year)

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205, owned and managed by itself, intends to file an application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $200,000.00.

The anticipated date of filing the application is: August 15, 2013.

The contact person for this project is E. Graham Baker, Jr., Attorney
(Contact Name) (Title)

who may be reached at: his office located at 2021 Richard Jones Rd. Suite 350
(Company Name) (Address)

Nashville TN 37215 615 /370-3380
(City) (State) (Zip Code) (Area Code / Phone Number)

E. Graham Baker, Jr. August 08, 2013 graham@grahambaker.net
(Signature) (Date) (E-mail Address)

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The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Frost Building
161 Rosa L. Parks Blvd., 3rd Floor
Nashville, Tennessee 37243

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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* The project description must address the following factors:

1. General project description, including services to be provided or affected.
2. Location of facility: street address, and city/town.
3. Total number of beds affected, licensure proposed for such beds, and intended uses.

COPY-
Application

MUA of Middle TN, LLC

CN1308-031

2013 AUG 15 PM 2 30

CERTIFICATE OF NEED APPLICATION

for the

Addition of Interventional Pain Management Services
to an existing ASTC

by

MUA of Middle Tennessee, LLC
28 White Bridge Rd # 210
Nashville, TN 37205

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
ANDREW JACKSON BUILDING
500 DEADERICK STREET, SUITE 850
NASHVILLE, TENNESSEE 37243

Filing Date: August 15, 2013

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency or Institution

2013 AUG 15 PM 2 30

MUA of Middle Tennessee, LLC
Name

28 White Bridge Road, #210 — Davidson
Street or Route — County

Nashville, — TN — 37205
City — State — Zip Code

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr. — Attorney
Name — Title

Weeks and Anderson — graham@grahambaker.net
Company Name — e-mail address

2021 Richard Jones Road, Suite 350 — Nashville, — TN — 37215
Street or Route — City — State — Zip Code

Attorney — 615/370-3380 — 615/221-0080
Association with Owner — Phone Number — Fax Number

3. Owner of the Facility, Agency, or Institution

MUA of Middle Tennessee, LLC — 615-352-3000
Name — Phone Number

28 White Bridge Road, #210 — Davidson
Street or Route — County

Nashville, — TN — 37205
City — State — Zip Code

4. Type of Ownership of Control (Check One)

A.	Sole Proprietorship	____	F.	Governmental (State of Tenn. or Political Subdivision)	____
B.	Partnership	____	G.	Joint Venture	____
C.	Limited Partnership	____	H.	Limited Liability Company	x
D.	Corporation (For-Profit)	____	I.	Other (Specify) _____	____
E.	Corporation (Not-for-Profit)	____			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See *Attachment A.4.*

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses' on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

Section A, Item 1: Facility Name must be applicant facility's name and address must be the site of the proposed project.

Response: MUA of Middle Tennessee, LLC ("Applicant") is the Applicant. See Response to A.1. The Applicant is currently located at 28 White Bridge Road, Suite 210, Davidson County, TN 37205, which is the site of the proposed project.

Section A, Item 3: Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

Response: See *Attachment A.4.*

Section A, Item 4: Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

Response: The Applicant is owned by its five members, and is member-managed. There is no organizational chart.

The five members of the Applicant are Lance C. Benedict, D.C. (21.5%), Terry Totty, D.C. (21.5%), Paul Yim, M.D. (12%), Mr. Michael Goorevich (6%), and Robert Odell, M.D. (39%).

The Applicant does not own any other health care institution in Tennessee, as defined in TCA §68-11-1602.

Section A, Item 5: For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

Response: Not applicable, as there is no management entity.

Section A, Item 6: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the tide/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

Response: The Applicant sub-leases space from Tennessee Spine and Nerve Institute, Inc., which currently leases the space from NOL, LLC, the landlord.

Attachment A.6 is a copy of the lease between the landlord and Tennessee Spine and Nerve Institute, Inc., and a *Attachment A.6.1* is an Assignment Agreement whereby the Applicant took over the existing lease from the Tennessee Spine and Nerve Institute, Inc., for the 1,493.4 GSF, the site of its specialty ASTC, already approved.

5. Name of Management/Operating Entity (If Applicable)

Not applicable
Name

Street or Route County

City State Zip Code

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. Not applicable.

6. Legal Interest in the Site of the Institution (Check One)

A.	Ownership		D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify)	
C.	Lease of 6 Years	x			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See *Attachments A.6 and A.6.1.*

7. Type of Institution (Check as appropriate--more than one response may apply.)

A.	Hospital		I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (Multi-Specialty)		J.	Outpatient Diagnostic Center	
			K.	Recuperation Center	
C.	ASTC	X	L.	Rehabilitation Facility	
D.	Home Health Agency		M.	Residential Hospice	
E.	Hospice		N.	Non-Residential Methadone Facility	
F.	Mental Health Hospital				
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
			P.	Other Outpatient Facility (Specify)	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q.	Other (Specify) specialty ASTC	X

8. Purpose of Review (Check as appropriate--more than one response may apply.)

A.	New Institution		H.	Change In Bed Complement (Please note the type of change by underlining the appropriate response: Increase, Decrease Designation, Distribution Conversion, Relocation)	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4)				
E.	Specify		I.	Change of Location	
F.	Discontinuance of OB Services		J.	Other (Specify) add interventional pain mgmt services	X
G.	Acquisition of Equipment				

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

Response: Not applicable, as no beds are involved in this application.

	Current Beds		Staffed	Beds	TOTAL Beds at
	Licensed	CON*	Beds	Proposed	Completion
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually-certified)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child & Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL					

*CON Beds approved but not yet in service

10. **Medicare Provider Number** 103G495427
Certification Type Specialty ASTC

11. **Medicaid Provider Number** 1531024
Certification Type Specialty ASTC

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?**

Response: This is an existing facility, certified for both Medicare and Medicaid.

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract. Discuss any out-of-network relationships in place with MCOs/BHOs in the area.***

Response: The Applicant has contracts with:

BLUECARE
AMERIGROUP
TENNCARE SELECT
BLUE ADVANTAGE
SECURE HORIZON
HUMANA GOLD CHOICE/EMERALD PLAN/DIAMOND PLAN
HEALTHSPRING MEDICARE ADVANTAGE PLAN
HEALTHSPRING COVENTRY
WINDSOR / MEDICARE EXTRA
GOLDEN RULE
UNITED MEDICAL RESOURCES
HERITAGE SELECT
STERLING OPTIONS I & II
MEDICARE COMPLETE
PYRAMID LIFE INSURANCE COMPANY
SEDGWICK
TODAY'S OPTIONS
UHC PLAN OF RIVER VALLEY
MEDICARE RAILROAD (RETIREMENT BOARD) FOR RAILROAD EMPLOYEES
DME CONTRACTORS FOR MEDICARE:
NATIONAL GOVERNMENT SERVICES: FOR REGION B
NORIDIAN FOR REGION D AND REGION A

Further, the Applicant will contract with any available or new MCOs as needed.

NOTE: *Section B is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. Section C addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.*

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, #210, Nashville, Davidson County, TN 37205, owned and managed by itself, files this application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $113,000, which includes the $3,000 filing fee.

MUA of Middle Tennessee, LLC is the Applicant. See response to A.1. The Applicant is currently located at 28 White Bridge Road, #210, Nashville, Davidson County, TN 37205.

The five members of the Applicant are Lance C. Benedict, D.C. (21.5%), Terry Totty, D.C. (21.5%), Paul Yim, M.D. (12%), Mr. Michael Goorevich (6%), and Robert Odell, M.D. (39%).

The Applicant sub-leases space from Tennessee Spine and Nerve Institute, Inc., which currently leases the space from NOL, LLC, the landlord. *Attachment A.6* is a copy of the lease between the landlord and Tennessee Spine and Nerve Institute, Inc., and a *Attachment A.6.1* is an Assignment Agreement whereby the Applicant took over the existing lease from the Tennessee Spine and Nerve Institute, Inc., for the 1,493.4 GSF, the site of its specialty ASTC, already approved.

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. Manipulation under Anesthesia ("MUA") is such a procedure, and the Applicant is already approved for this service.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the early 1930s. The process involves relaxing the patient (with

anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

The Applicant is forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. These measures include interventional pain management services such as joint injections. The HSDA originally determined that such procedures were included under MUA, and the Applicant provided such procedures for some time. Later, the HSDA determined that the Applicant is not approved for such interventional pain management services. Since the Applicant cannot conduct the MUA procedures for which it has already been approved without attempting interventional pain management procedures first, this application is being filed.

Project Costs: There are no costs, other than administrative, for this project. The facility, as approved and licensed, will not require any modification. The FMV and lease costs for the ASTC have already gone through CON when the ASTC was approved. Equipment is already in place.

Staff: The Applicant will utilize existing staff, including an administrator ($12K - $15K annually), a receptionist ($13/hour), RN ($25K-$30K annually), and a Rad Tech ($20- $23/hour). No additional staff will be needed for this project.

Charges: The Applicant anticipates an average gross charge per patient in Year 1 of operation of $1,345, with an average deduction of $1,076, for an average net charge of $269 per patient. Interventional pain management procedures can be performed in physician's offices, in hospitals, and in other approved facilities. However, it is difficult, and almost impossible, to arrive at comparable charges for such services since such charges are not reported on Joint Annual Reports. The Applicant has made an attempt to compare these charges, as will be discussed later in the application.

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

Medicare and TennCare Revenue Projections: It is anticipated that 40% of our patients will be Medicare, 10% will be Medicaid, 45% will be commercial patients and 5% will be private pay.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

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Medicare and TennCare Revenue Projections: It is anticipated that 40% of our patients will be Medicare, 10% will be Medicaid, 45% will be commercial patients and 5% will be private pay.

The current ASTC room configuration is noted on *Attachment B.IV.* Note that there is only one Procedure Room. This room is already approved, and will be utilized for interventional pain management services. It is also important to note that only one patient will be served at a time, and each patient will receive only one service during a visit. Some procedures require mild sedation, and anesthesia will be administered by either an Anesthesiologist or a CRNA working for an Anesthesiologist. Patients must have medical clearance for anesthesia. Also, patients have to have had testing for the procedure (standard testing is CBS/Diff and sometimes an SMA6). If the patient is over 50 years of age, they will need an EKG; if the patient has a history of respiratory difficulty, a Chest X-Ray will be required. Finally, a pregnancy test will be given to female patients.

Both the person administering anesthesia and the recovery room nurse must be ACLS certified in life support. Following the procedure, each patient will go to the Recovery Room for gentle stretching and physical therapy, including Interferential (electrical stimulation) therapy, and then ice. Following this, the patient will have a massage prior to discharge.

Following the procedure, most patients are fully capable of ambulation. However, in some instances it may be advised that someone (either our staff, a family member, or friend) drive the patient to their destination in order for the patient to receive rest and relaxation.

The Applicant has worked with both the HSDA and the Tennessee Department of Health, Division of Licensing Health Care Facilities, to coordinate useful licensing requirements and utilization standards for facilities such as have been approved for this ASTC. Representatives of the Applicant have met with a representative of the Board for Licensing Health Care Facilities in this regard. For example, please see *Attachment C.N.5* for a copy of working protocols for MUA procedures.

According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. Our existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. *Attachment C.OD.3* contains affiliated health care workers data.

The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors have been trained in the clinic, and this process will continue.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: Not applicable, as no beds are involved in this project.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20 Rehabilitation Services
21. Swing Beds

Response: Not applicable.

D. Describe the need to change location or replace an existing facility.

Response: Not applicable.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

1. Total cost; (As defined by Agency Rule)
2. Expected useful life;
3. List of clinical applications to be provided; and
4. Documentation of FDA approval.

b. Provide current and proposed schedules of operations.

Response: Not applicable.

2. For mobile major medical equipment:
a. List all sites that will be served;
b. Provide current and/or proposed schedule of operations;
c. Provide the lease or contract cost.
d. Provide the fair market value of the equipment; and
e. List the owner for the equipment.

Response: Not applicable.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response: Not applicable.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. **Size of site (*in acres*)**
2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response:

1. The site on which the medical building is located is approximately 2.31 Acres.

2. See *Attachment B.III.2.*

3. There is no construction. See *Attachment B.III.3* to show the location of the existing ASTC.

4. The ASTC is located in existing space on the second floor of the office building located at 28 White Bridge Road, Nashville, Tennessee. The site has easy access to White Bridge Road, which is a major East/West corridor connecting West End Avenue with Charlotte Pike and I40 in the western section of Nashville. The site is perhaps 10 minutes drive time from downtown Nashville.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: Buses run on White Bridge Road, West End Avenue, and Charlotte Pike, and private taxis are also available. As the site of the proposed facility is on White Bridge Road, the site is readily accessible for patients.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: *DO NOT SUBMIT BLUEPRINTS*. Simple line drawings should be submitted and need not be drawn to scale.

Response: Please see *Attachment B.IV*, which contains a footprint of that section of the second floor of the office building where the ASTC is located.

V. For a Home Health Agency or Hospice, identify:

1. **Existing service area by County;**
2. **Proposed service area by County;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

Response: Not applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. **Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**

   a. **Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.**

Response: Please see *Attachment Specific Criteria.*

   b. **Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).**

Response: Not applicable.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response: There is no long-range development plan of the Applicant, other than to add interventional pain management services to this existing ASTC. The Applicant was originally approved to provide MUA services. After licensure, the Applicant began providing the service, and insurers advised the Applicant that they would not reimburse for MUA unless and until interventional pain management services were attempted first. The Applicant requested a determination from the HSDA as to whether or not such procedures were "covered" under the heading of MUA. Obviously, the Applicant felt they were covered. The HSDA agreed, and the Applicant resumed providing services in compliance with both Licensure and third party insurers. Later, the HSDA decided that the Applicant was not approved for interventional pain management procedures, and the Applicant had to shut down its operation. After several meetings and exchange of information among the interested parties, the Applicant decided to apply for interventional pain management services via this application.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).

Response: The Applicant's service area consists of Davidson, Williamson, Rutherford and Robertson Counties (patient origin of 98% of the patients of Tennessee Spine and Nerve Institute, Inc., in 2009, in order by county).

See *Attachment C.N.3* for a map of the proposed service area.

It is important to note that the service area for this project is based, in large part, on the actual patient origin information for two of the member/owners of the Applicant. Drs. Benedict and Totty currently serve patients from about 7 Middle Tennessee Counties, and the four top counties, in order of number of patients, are: Davidson, Williamson, Rutherford and Robertson Counties.

4. A. **Describe the demographics of the population to be served by this proposal.**

Response: The primary area to be served (Davidson, Williamson, Rutherford and Robertson County residents) is an urban community with rural and industrial influences. Davidson County is the hub of Middle Tennessee, and the population numbers of some of the counties in Middle Tennessee are increasing at a high rate (e.g., Williamson and Rutherford Counties). Metropolitan Nashville/Davidson County is also the hub of the Nashville-Murfreesboro Standard Metropolitan Statistical Area (SMSA) in Middle Tennessee. Please see *Attachment C.N.4.A* for a listing of Quick Facts about the four counties in our service area.

The following chart lists 2013, 2015 and 2017 population estimates for the service area:

Population Estimates for Service Area

County	Estimated 2013 Population	Estimated 2015 Population	Estimated 2017 Population
Davidson	605,923	614,222	622,476
Williamson	188,259	196,824	203,870
Rutherford	261,331	271,112	278,888
Robertson	69,680	72,006	73,853
TOTAL	1,125,193	1,154,164	1,179,087

Source: Population Estimates and Projections, Tennessee Counties and the State, 2010 – 2020, Office of Health Statistics, Bureau of Health Informatics, Tennessee Department of Health.

Attachment C.N.4.A contains demographic data for the service area. This data was obtained from the US Census Bureau.

B. **Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.**

Response: There are no special needs of the service area population, as contemplated by this question. The Applicant feels that there are individuals in need of interventional pain management services, in addition to the approved MUA services, however.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: There are several hospitals and ASTCs in the service area that provide interventional pain management services. None of these facilities provide such services in conjunction with MUA, however. MUA protocols are included as *Attachment C.N.5.*

Attachment C.N.5.A is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: There is not sufficient historical utilization for the Applicant due to the fact interventional pain management services were just starting to be provided for a time, prior to the HSDA reversing that approval.

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

-- **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**

-- **The cost of any lease should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.**

-- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

-- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response: The Project Costs Chart is completed. This Application includes administrative costs, and a relatively small amount for equipment, only, and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved.

PROJECT COSTS CHART

2013 AUG 15 PM 2 31

A.	Construction and equipment acquired by purchase.	
1.	Architectural and Engineering Fees	
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant	50,000 .00
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs (Possible Renovation)	
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment (List all equipment over $50,000) (NONE OVER $50K)	60,000 .00
9.	Other (Specify)	
	Subsection A Total	**110,000 .00**
B.	Acquisition by gift, donation, or lease.	
1.	Facility (Inclusive of Building and Land) (Estimated FMV)	0 .00
2.	Building Only	
3.	Land Only	
4.	Equipment (Specify)	
5.	Other (Specify)	
	Subsection B Total	**0 .00**
C.	Financing costs and fees	
1.	Interim Financing	0 .00
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	
	Subsection C Total	**0 .00**
D.	Estimated Project Cost (A + B + C)	**$ 110,000.00**
E.	CON Filing Fee	**$ 3,000.00**
F.	Total Estimated Project Cost (D + E) TOTAL	**$ 113,000.00**

2. **Identify the funding sources for this project.**

   a. **Please check the applicable item(s) below and briefly summarize how the project will be financed.** ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

___ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

___ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

___ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**

___ **D. Grants--Notification of intent form for grant application or notice of grant award; or**

_x_ **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

___ **F. Other—Identify and document funding from all other sources.**

Response: The Applicant has space under lease at the present time. This Application includes administrative costs, and a relatively small amount for equipment, only (already purchased), and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved. Cash reserves have been utilized to pay for these nominal costs.

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

Response: This Application includes administrative costs, and a relatively small amount for equipment, only (already purchased), and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved.

The most recent comparable ASTC approved by the HSDA was the PCET Surgery Center in Knoxville, approved at the May 23, 2012 HSDA meeting. That particular project cost was $1,396,681.

The Surgical and Pain Treatment Center of Clarksville, LLC was denied at the December 12, 2012 meeting of the HSDA, and the project cost of that project was $1,012,993.

Therefore, our project cost is extremely reasonable.

4. **Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

Response: Historical and Projected Data Charts are attached.

Historical Data Chart:

There is not sufficient historical utilization for the Applicant due to the fact interventional pain management services were just starting to be provided for a time, prior to the HSDA reversing that approval.

Projected Data Chart:

This chart includes projected data for interventional pain management procedures for the Applicant. Note that the Applicant anticipates positive cash flow in both years.

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (month).

2013 AUG 15 PM 2 31

Response:

		Yr-1	Y-2	Yr-3
A.	Utilization/Occupancy Rate (visits)	0	0	0
B.	Revenue from Services to Patients			
	1. Inpatient Services	0	0	0
	2. Outpatient Services	0	0	0
	3. Emergency Services	0	0	0
	4. Other Operating Revenue (Specify) _____	0	0	0
	Gross Operating Revenue	**0**	**0**	**0**
C.	Deductions from Operating Revenue			
	1. Contractual Adjustments	0	0	0
	2. Provision for Charity Care	0	0	0
	3. Provision for Bad Debt	0	0	0
	Total Deductions	**0**	**0**	**0**
	NET OPERATING REVENUE	**0**	**0**	**0**
D.	Operating Expenses	0	0	0
	1. Salaries and Wages	0	0	0
	2. Physician's Salaries and Wages	0	0	0
	3. Supplies	0	0	0
	4 . Taxes	0	0	0
	5 . Depreciation	0	0	0
	6. Rent	0	0	0
	7. Interest, other than Capital	0	0	0
	8. Other Expenses (Specify) _____	0	0	0
	Total Operating Expenses	**0**	**0**	**0**
E.	Other Revenue (Expenses)-Net (Specify)	0	0	0
	NET OPERATING INCOME (LOSS)	**0**	**0**	**0**
F.	Capital Expenditures			
	1. Retirement of Principal	0	0	0
	2. Interest	0	0	0
	Total Capital Expenditure	**0**	**0**	**0**
	NET OPERATING INCOME (LOSS) LESSCAPITAL EXPENDITURES	**0**	**0**	**0**

PROJECTED DATA CHART
(Interventional Pain Management)

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

2013 AUG 15 PM 2:31

		Yr-1	Yr-2
A.	Utilization/Occupancy Rate *(surgical patients))*	3,455	4,442
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services	4,646,975	5,974,490
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**4,646,975**	**5,974,490**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	3,299,352	4,241,887
	2. Provision for Charity Care	232,348	298,724
	3. Provision for Bad Debt	185,879	238,979
	Total Deductions	**3,717,579**	**4,779,590**
	NET OPERATING REVENUE	**929,396**	**1,194,900**
D.	Operating Expenses		
	1. Salaries and Wages	125,000	128,750
	2. Physician's Salaries and Wages (Medical Director)	337,500	357,750
	3. Supplies	120,000	135,000
	4. Taxes	25,800	38,460
	5. Depreciation	11,316	11,316
	6. Rent	40,380	45,272
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses (Specify) office supplies, advertising, insurance utilities	138,800	138,800
	Total Operating Expenses	**798,796**	**855,348**
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	**130,600**	**339,552**
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**130,600**	**339,552**

PROJECTED DATA CHART
(Total Facility)

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

2013 AUG 15 PM 2 31

		Yr-1	Yr-2
A.	Utilization/Occupancy Rate *(surgical patients))*	3,605	4,627
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services	6,896,975	8,749,490
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**6,896,975**	**8,749,490**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	4,896,852	6,212,137
	2. Provision for Charity Care	356,098	451,349
	3. Provision for Bad Debt	298,379	377,779
	Total Deductions	**5,551,329**	**7,041,265**
	NET OPERATING REVENUE	**1,345,646**	**1,707,865**
D.	Operating Expenses		
	1. Salaries and Wages	125,000	128,750
	2. Physician's Salaries and Wages (Medical Director)	337,500	357,750
	3. Supplies	148,000	169,533
	4. Taxes	25,800	34,5330
	5. Depreciation	11,316	11,316
	6. Rent	39,633	40,380
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses (Specify) office supplies, advertising, insurance, utilities	138,800	138,800
	Total Operating Expenses	**825,249**	**881,062**
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	**520,397**	**826,803**
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**520,397**	**826,803**

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: See (rounded) projected figures below for Year 1:

$	1,345	Average Gross Charge per procedure
$	1,076	Average Deduction from Operating Revenue per procedure
$	269	Average Net Charge per procedure.

The above charges are facility charges, only. Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals.

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: There are no current charges. See (rounded) projected figures below for Year 1:

$	1,345	Average Gross Charge per procedure
$	1,076	Average Deduction from Operating Revenue per procedure
$	269	Average Net Charge per procedure.

The above charges are facility charges, only. Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals.

Anticipated revenue from the proposed project indicate a positive cash flow for the first two years of operation.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: *Attachment C.N.5.A* is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

7. **Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.**

Response: The Projected Data Chart indicates sufficient income to maintain cost-effectiveness, with a positive cash flow for both projected years. Obviously, income is dependent upon rendering services to a sufficient number of patients. The Applicant believes such will be the case.

8. **Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.**

Response: The Projected Data Chart indicates sufficient income to maintain cost-effectiveness, with a positive cash flow for both projected years. Obviously, income is dependent upon rendering services to a sufficient number of patients. The Applicant believes such will be the case.

9. **Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

Medicare and TennCare Revenue Projections: Based on the patients seen by the Applicant when interventional pain management services were being provided, we anticipate the following patients:

Medicare	40%
Medicaid	10%
Commercial	45%
Private Pay	5%

Based on these projections, it is anticipated that the impact on Medicare will be as follows:

$4,646,975 x 40% = $1,858,790.

Likewise, it is anticipated that the impact on Medicaid will be as follows:

$4,646,975 x 10% x 30% State Share = $139,410.

10. **Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.**

Response: Please see *Attachment C.EF.10.*

11. **Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:**

a. **A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.**

Response: There were no other viable alternatives considered.

As stated earlier, the Applicant was approved to provide MUA services. When we began the procedures, we were advised by the insurers that we had to attempt interventional pain management procedures first, or we would not be compensated for the traditional MUA procedure. We felt that interventional pain management procedures were a part of MUA, and requested a determination from the HSDA to that extent. We were approved by the HSDA to perform these procedures, and we did so. Later, the HSDA decided we could not perform such procedures and we had to cease providing them. Since we cannot be compensated for what we have already been approved for, we had to submit this application.

b. **The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.**

Response: There were no other viable alternatives considered.

As stated earlier, the Applicant was approved to provide MUA services. When we began the procedures, we were advised by the insurers that we had to attempt interventional pain management procedures first, or we would not be compensated for the traditional MUA procedure. We felt that interventional pain management procedures were a part of MUA, and requested a determination from the HSDA to that extent. We were approved by the HSDA to perform these procedures, and we did so. Later, the HSDA decided we could not perform such procedures and we had to cease providing them. Since we cannot be compensated for what we have already been approved for, we had to submit this application.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

Response: The Applicant has a contractual relationship with St. Thomas Hospital. Please see *Attachment C.OD.1.*

2. **Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

Response: The approval of this application should not have a material adverse impact on any health care providers in the State. There are no facilities in our service area that are dedicated to the provision of both interventional pain management and MUA procedures.

To our knowledge (based on JARs) we are not aware of any hospitals who provide interventional pain management services exclusively, and cannot compare our data to the JARs. There are 4 ASTCs that appear to limit their respective services to interventional pain management services, but those facilities operated at 2,289 procedures per room in 2012 (Attachment C.N.5.B lists all ASTCs that provide pain management services, and the 2012 data for these 4 ASTCs show that 25,171 procedures were performed in 11 procedure rooms). Since these facilities are operating well above the Guidelines, there should be no material adverse impact on these facilities when our application is approved.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. *Attachment C.OD.3* contains affiliated health care workers data.

Existing staff at the Applicant's ASTC will be utilized for this service, and no new staff will be required.

The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors have been trained in the ASTC.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. *Attachment C.OD.3* contains affiliated health care workers data.

Existing staff at the Applicant's ASTC will be utilized for this service, and no new staff will be required.

The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors are trained in the ASTC.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.***

Response: The Applicant is familiar with licensing certification requirements for an ASTC, as the facility is already licensed.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).**

Response: The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors have been trained in the ASTC.

7. **(a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

Response: The Applicant is familiar with licensing certification requirements for an ASTC, as the facility is already licensed.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response:

Licensure: Tennessee Department of Health.

Accreditation: Medicaid, Medicare, TennCare, AAAHC.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: The ASTC is licensed. Please see Attachment C.OD.7(c).

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: Please see Attachment C.OD.7(d), which includes both TDOH Licensure survey and AAAHC survey information.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response: There have been no final orders or judgments as are contemplated by this question.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

Response: There have been no final orders or judgments as are contemplated by this question.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Response: The Applicant will provide all data contemplated by this question.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: Please see attached tear sheet from *The Tennessean.*

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 12/2010.

2013 AUG 15 PM 2 31

Assuming the CON approval becomes the final agency action on that date; indicate the number of day **from the above agency decision date** to each phase of the completion forecast.

Phase	**DAYS REQUIRED**	**Anticipated Date (MONTH/YEAR)**
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy (renovation)		
10. *Issuance of license	60	02/2014
11. *Initiation of service	60	02/2014
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

*** For projects that do NOT involve construction or renovation : Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

60

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

2013 AUG 15 PM 2 31

E. Graham Baker, Jr., being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of his/her knowledge.

E Graham Baker, Jr /Attorney
SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of August, 2013, a
(month) (year)

Notary Public in and for the County/State of Davidson/Tennessee.

Nadean E Poteet
NOTARY PUBLIC

NADEAN E. POTEET STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY

My commission expires July 3rd, 2017.
(Month/Day) (Year)

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

AMBULATORY SURGICAL TREATMENT CENTERS

Determination of Need

1. **Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

2. **Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

The ASTC will be available Monday through Friday, 8 hours per day. This means that the ASTC will be available 120,000 minutes per year (5 days x 8 hours x 60 minutes x 50 weeks), meaning that in Year 1, 34 minutes will be available for each procedure, and in Year 2, about 27 minutes will be available for each procedure. Since each procedure will take less than 15 minutes, sufficient time will be available.

3. **Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.**

Response:

Attachment C.N.5.A is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

The approval of this application should not have a material adverse impact on any health care providers in the State. There are no facilities in our service area that are dedicated to the provision of both interventional pain management and MUA procedures.

To our knowledge (based on JARs) we are not aware of any hospitals who provide interventional pain management services exclusively, and cannot compare our data to the JARs. There are 4 ASTCs that appear to limit their respective services to interventional pain management services, but those facilities operated at 2,289 procedures per room in 2012 (Attachment C.N.5.B lists all ASTCs that provide pain management services, and the 2012 data for these 4 ASTCs show that 25,171 procedures were performed in 11 procedure rooms). Since these facilities are operating well above the Guidelines, there should be no material adverse impact on these facilities when our application is approved.

4. **Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their**

referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Response:

Attachment C.N.5.A is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

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5. **Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

The ASTC will be available Monday through Friday, 8 hours per day. This means that the ASTC will be available 120,000 minutes per year (5 days x 8 hours x 60 minutes x 50 weeks), meaning that in Year 1, 34 minutes will be available for each procedure, and in Year 2, about 27 minutes will be available for each procedure. Since each procedure will take less than 15 minutes, sufficient time will be available.

Other Standards and Criteria

6. **Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.**

Response:

The majority of patients in the service area will reside within 60 minutes average driving time to our facility.

7. **Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.**

Response:

Buses run on White Bridge Road, West End Avenue, and Charlotte Pike, and private taxis are also available. As the site of the proposed facility is on White Bridge Road, the site is readily accessible for patients.

8. **Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

Response:

The Applicant's service area consists of Davidson, Williamson, Rutherford and Robertson Counties (patient origin of 98% of the patients of Tennessee Spine and Nerve Institute, Inc., in 2009, in order by county).

9. **Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment**

center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Response:

It is anticipated that utilization will be as follows:

1st Quarter	863 procedures
2nd Quarter	864 procedures
3rd Quarter	864 procedures
4th Quarter	864 procedures
5th Quarter	1,110 procedures
6th Quarter	1,110 procedures
7th Quarter	1,111 procedures
8th Quarter	1,111 procedures

10. <u>Patient Safety and Quality of Care; Health Care Workforce</u>.

    a. **An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.**

    b. **An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.**

Response:

The Applicant is licensed by the TDOH, is certified by both Medicare and Medicaid, and is accredited by AAAHC.

To date, at least 4 physicians have utilized our ASTC.

11. <u>Access to ASTCs</u>. **In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:**

    a. **Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;**

    b. **Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;**

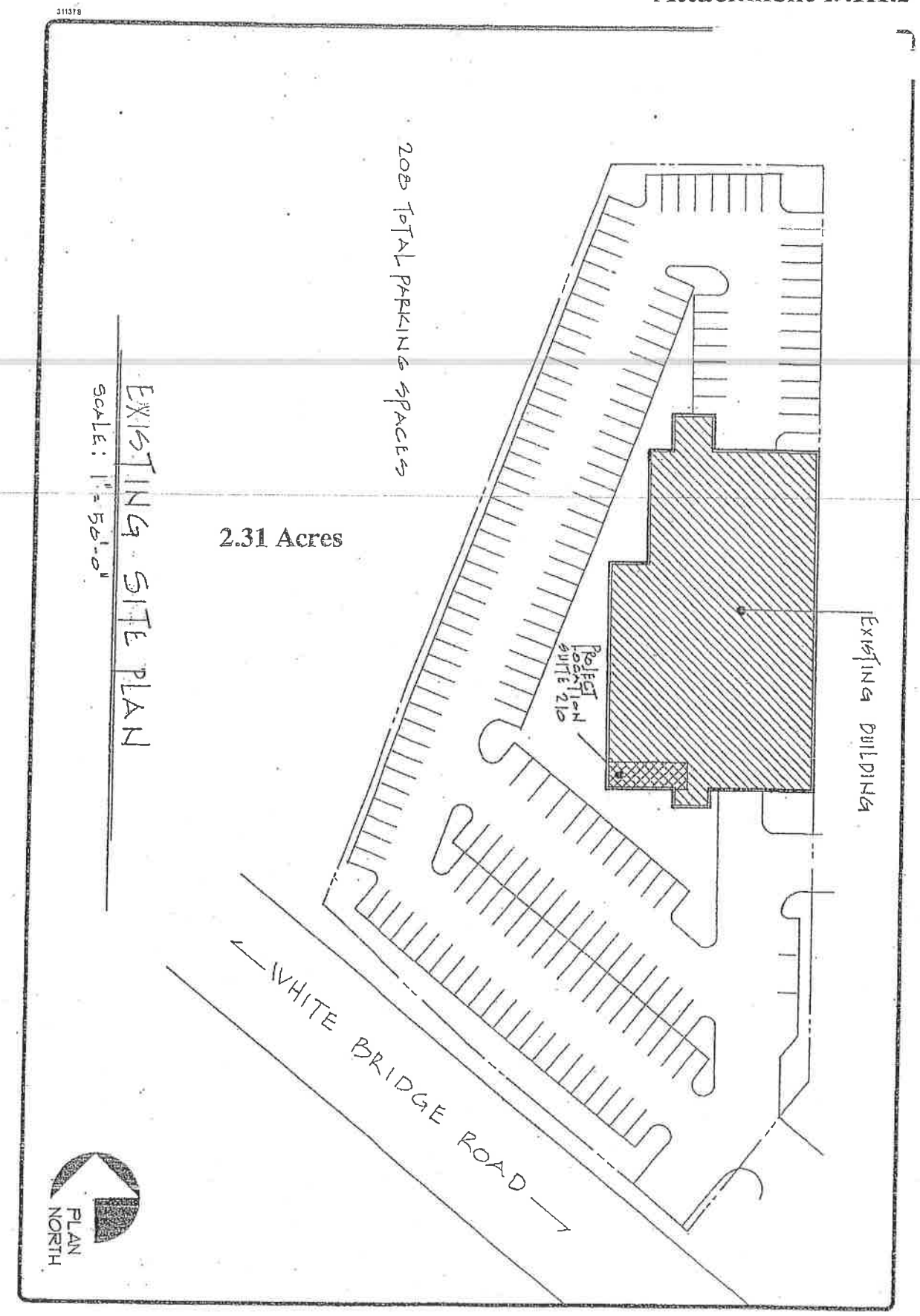
    c. **Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or**

d. **Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.**

Response:

The Applicant agrees that every citizen should have reasonable access to health care. When we opened our ASTC, patients started coming to our facility. Unfortunately, we were forced to shut it back down due to a change by the HSDA. We contract with:

BLUECARE
AMERIGROUP
TENNCARE SELECT
BLUE ADVANTAGE
SECURE HORIZON
HUMANA GOLD CHOICE/EMERALD PLAN/DIAMOND PLAN
HEALTHSPRING MEDICARE ADVANTAGE PLAN
HEALTHSPRING COVENTRY
WINDSOR / MEDICARE EXTRA
GOLDEN RULE
UNITED MEDICAL RESOURCES
HERITAGE SELECT
STERLING OPTIONS I & II
MEDICARE COMPLETE
PYRAMID LIFE INSURANCE COMPANY
SEDGWICK
TODAY'S OPTIONS
UHC PLAN OF RIVER VALLEY
MEDICARE RAILROAD (RETIREMENT BOARD) FOR RAILROAD EMPLOYEES
DME CONTRACTORS FOR MEDICARE:
NATIONAL GOVERNMENT SERVICES: FOR REGION B
NORIDIAN FOR REGION D AND REGION A

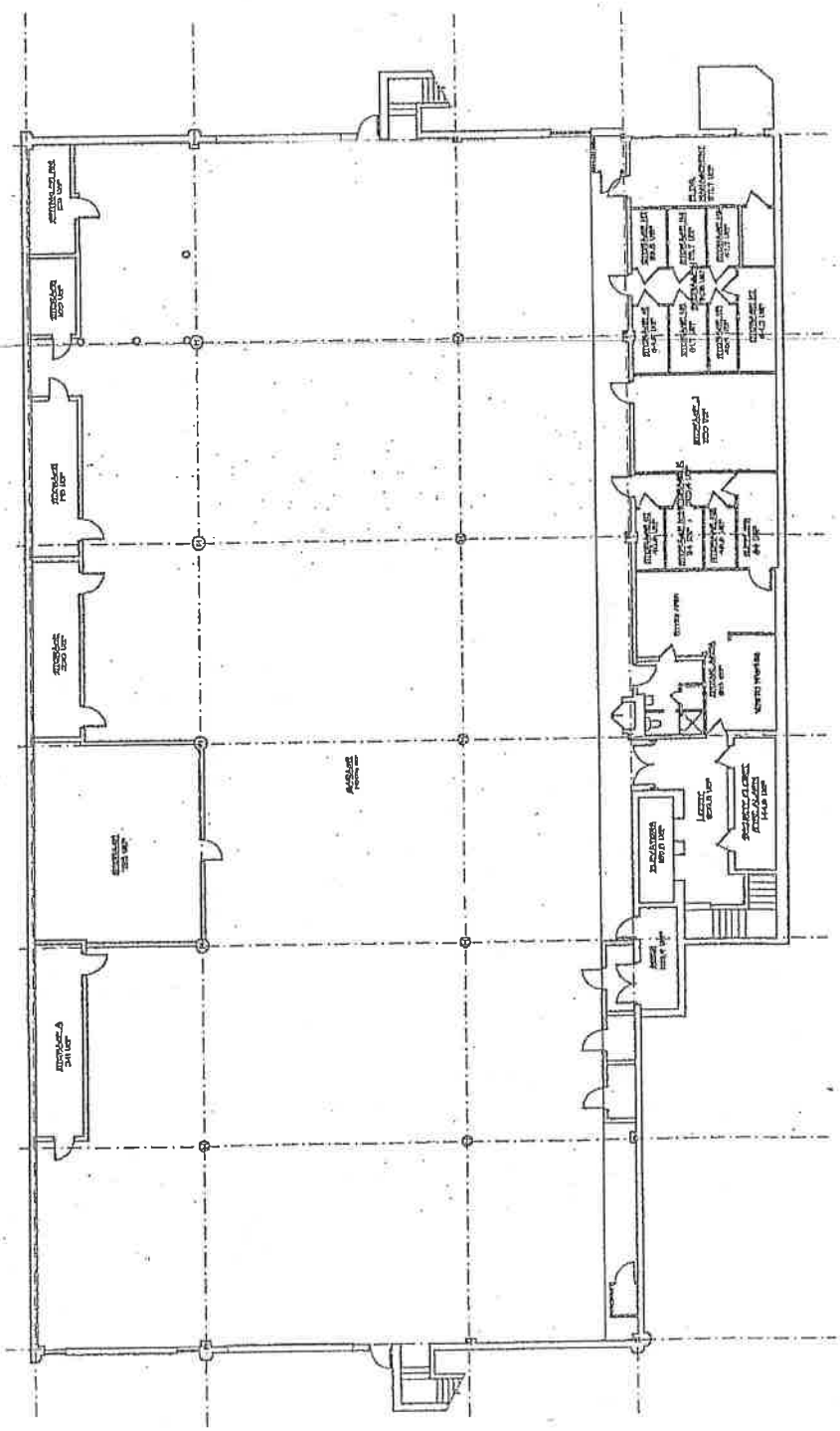


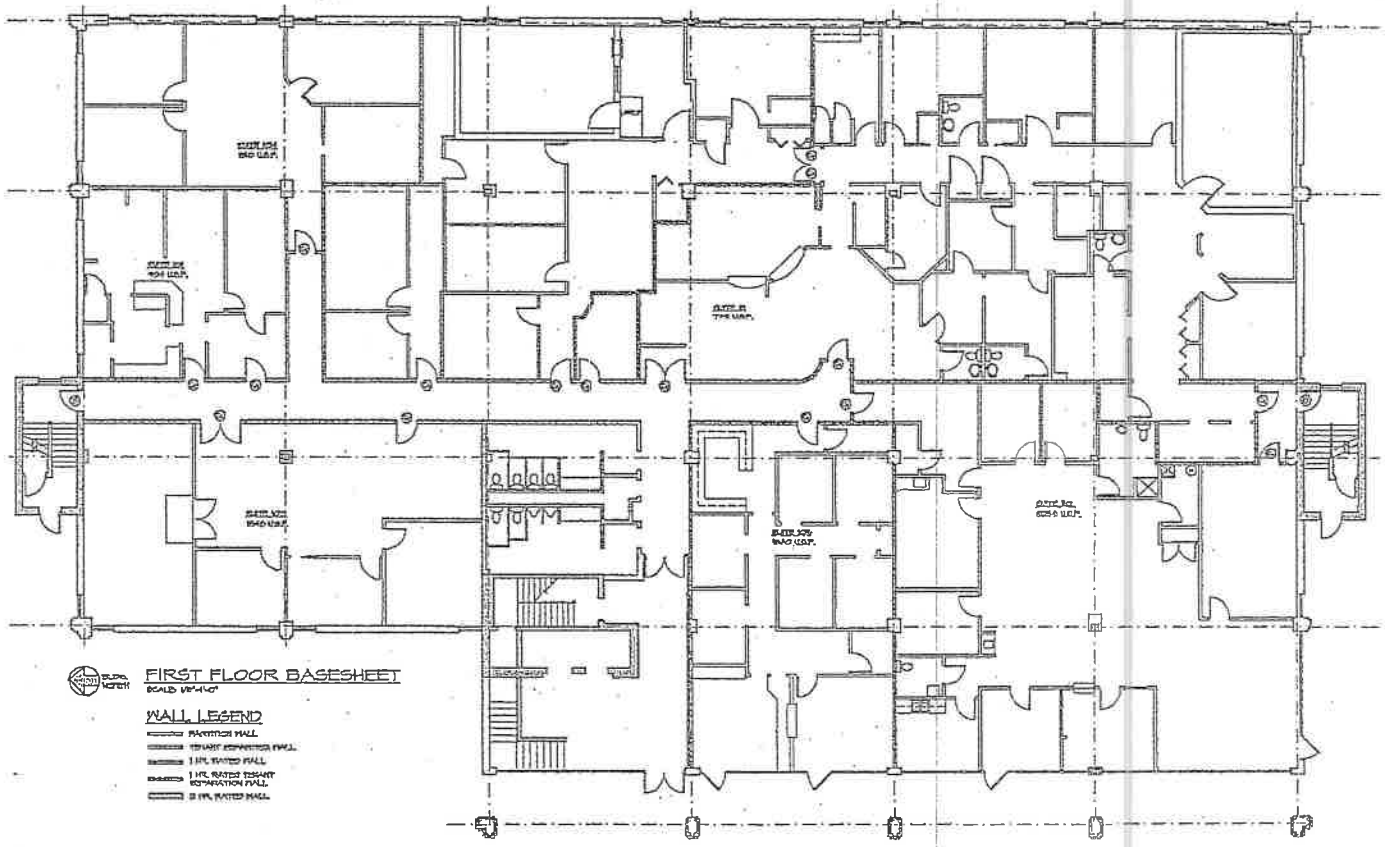
CM-1	9/16/2010	MUA OF MIDDLE TENNESSEE, LLC SUITE 210 28 WHITE BRIDGE ROAD NASHVILLE , TENNESSEE

ANDERSON BUILDING

ANDERSON BUILDING

January 28, 2003





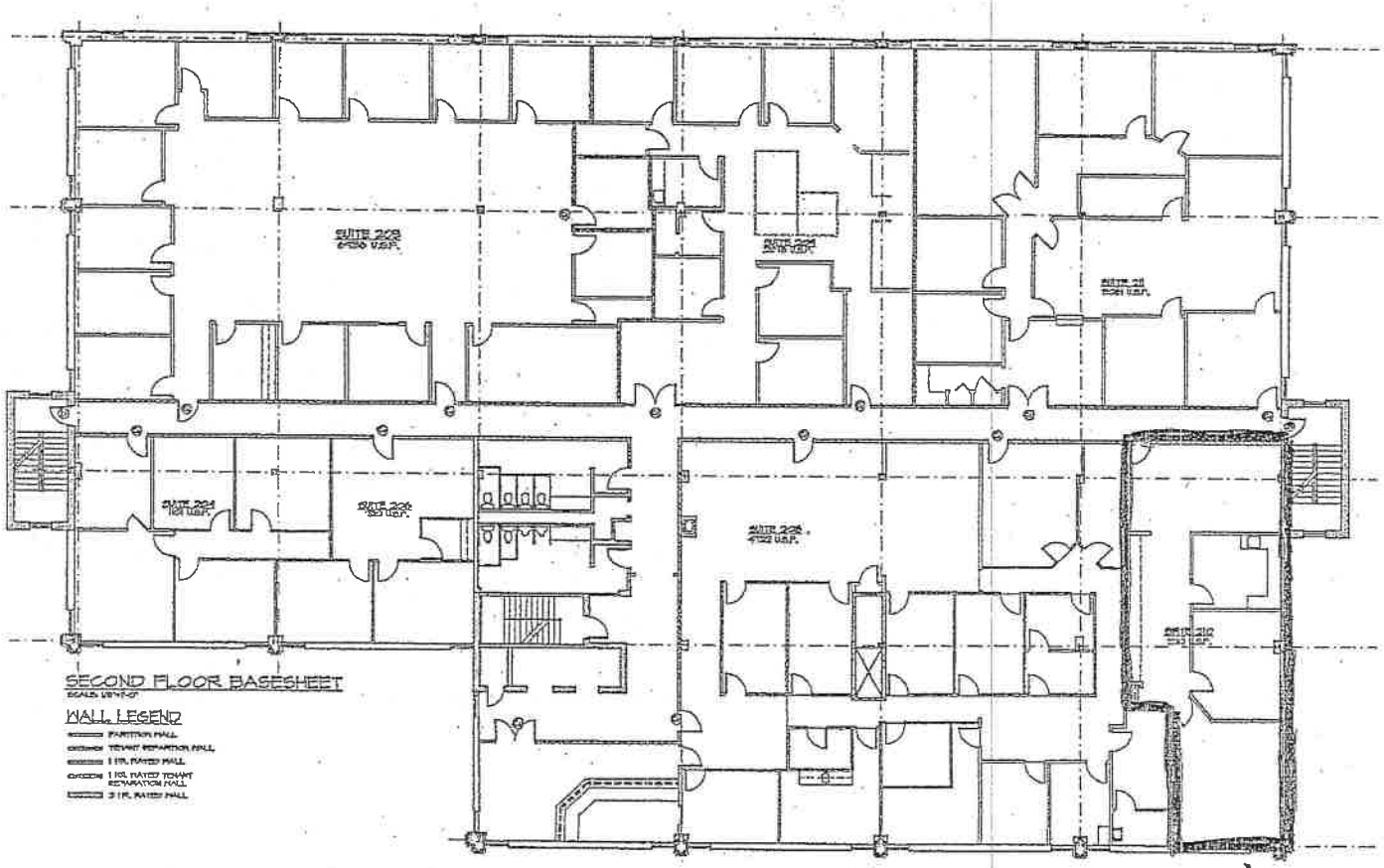
FIRST FLOOR BASESHEET

WALL LEGEND

DOOR TYPES

ANDERSON BUILDING

January 23, 2008



SECOND FLOOR BASESHEET

WALL LEGEND

- PARTITION WALL
- TENANT SEPARATION WALL
- 1 HR. RATED WALL
- 1 HR. RATED TENANT SEPARATION WALL
- 2 HR. RATED WALL

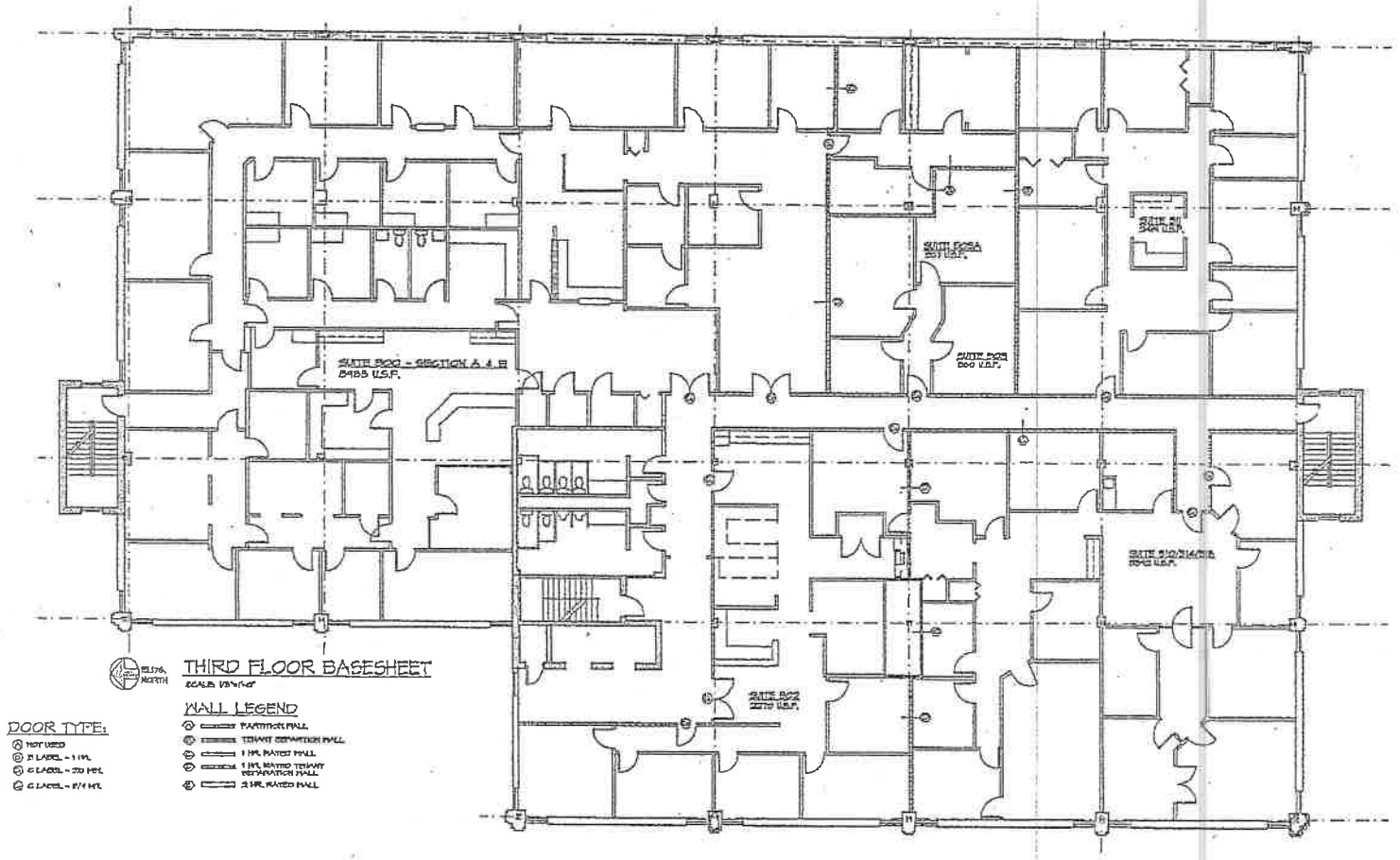
DOOR TYPES:

- A NOT USED
- B 3 LABEL - 1 HR.
- C 6 LABEL - 20 MIN.
- D 6 LABEL - 1½ HR.

ASTC

ANDERSON BUILDING

January 23, 2003

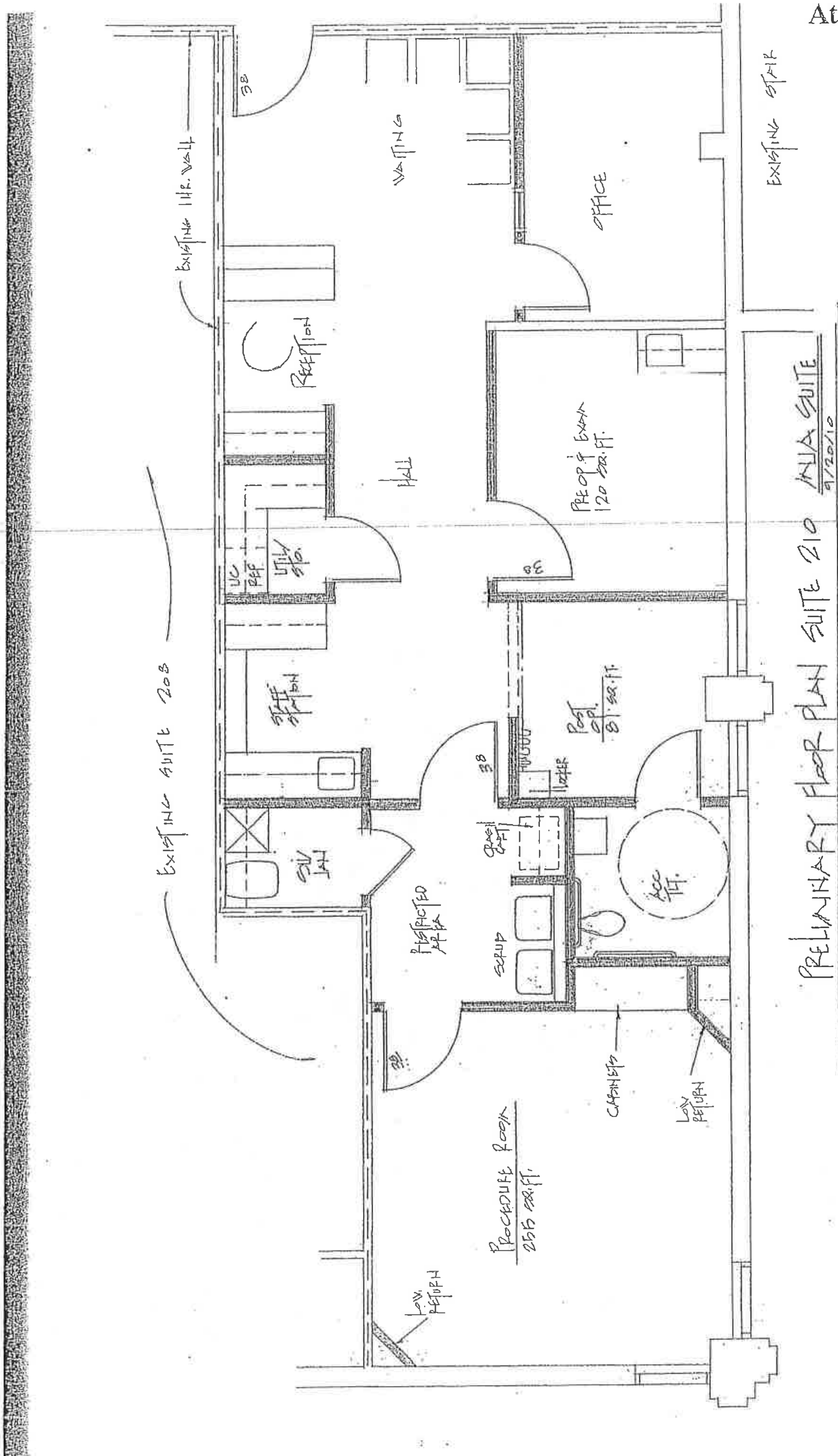


THIRD FLOOR BASESHEET

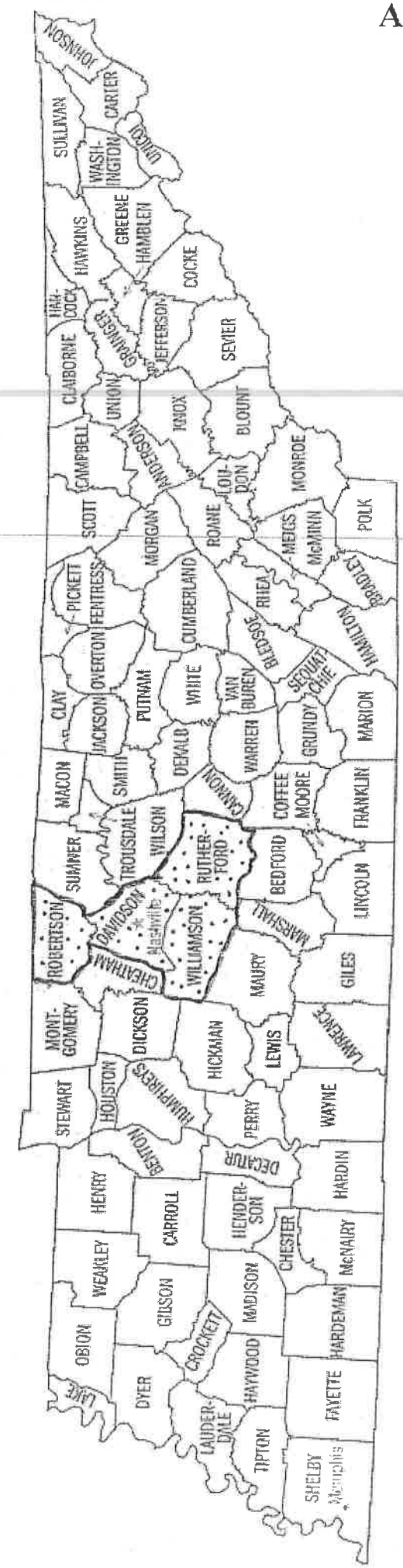
DOOR TYPES:

WALL LEGEND

January 31, 2008


EXISTING STAIR
OFFICE
WAITING
EXISTING INT. WALL
RECEPTION
HALL
PREOP & EXAM
120 SQ. FT.
POST OP.
81 SQ. FT.
LOCKER
EXISTING SUITE 203
RESTRICTED AREA
SCRUB
PROCEDURE ROOM
256 SQ. FT.
CABINETS
LOW RETURN
PRELIMINARY FLOOR PLAN SUITE 210
1/4" = 1'-0"

Tennessee County Map



Policies and Procedures for Manipulation Under Anesthesia

Robert C. Gordon, D.C., FABCS, FRCCM, DAAPM

Purpose

The purpose of writing these policies and procedures is for facilities or doctors or the staff of a facility to have a guideline for providing the service of the technique of Manipulation Under Anesthesia (MUA). It will be used in conjunction with the National Academy of MUA Physicians standards and protocols, and will be used to determine the types of doctors who may use the facilities for MUA; the educational standards required for staff privileges for the use of MUA; for the patient logistical movement in the facility; the required policy for the use of the MUA procedure; the basis for clinical selection of cases for the MUA procedures; the accepted and suggested follow-up post care requirement for the MUA patients; and for the overall guidelines for the MUA procedures that may not be part of the mentioned areas above.

Educational Standards

It shall be the policy of this facility that the doctors that are performing this procedure must have achieved 36 hours of postgraduate instruction in MUA from a CCE/CME accredited Chiropractic or Medical school, and that those hours contain education in: The history of the MUA procedure; the scientific basis of the MUA procedure; the clinical application of the patients for MUA; the proper selection of the patients for MUA (use of the NAMUAP standards and protocols); two week-ends of education in MUA consisting of a didactic education and workshops, an examination both oral and written, and a second week-end which allows the doctors to be proctored on actual patients with hands on training in the MUA procedure. This standard of education has long been the standard of education for MUA since its inception, and has been taught by the original MUA instructors since the late 80's in the chiropractic profession. Since the MDs and the DOs have no formal MUA program at this time in their institutions most MDs and DOs have been taking their training from the chiropractic profession. There is a preponderance of evidence that the education of the doctors performing this procedure must follow extensive standards that have long been the standard of education to understand the full process of MUA. There is also evidence that if proper education in the area of billing and working with insurance companies is not completed properly there is no proper follow-up for graduating doctors, and therefore no education in the proper use of coding, and fee structures. This should be considered when a doctor becomes a part of a facility. The doctors that use this facility must have an idea of proper billing procedures, and must follow standards that allow for conservative billing practices as taught in the long standing older courses. The older courses still teach proper billing practices and therefore will be used as the gold standard for any doctor that has taken the training.

Proper Patient Selection

It shall be the policy of the facility that the proper selection of patients for this procedure should be foremost in the mind of the practitioner of MUA. Proper selection of the patient is the purest form of proper outcomes, and the essence of a good MUA program is the highest recovery rate possible from those patients selected to undergo MUA. The use of the National Academy of

MUA Physicians is a good start for this section. Other algorithms that follow standard care for various conditions may also be formatted to fit this particular section, and may be included in additional appendixes within this policies and procedures protocols.

Clinical Efficacy of Manipulation Under Anesthesia(MUA)

It has long been the practice of the doctor involved in physical medicine and chiropractic that the movement, mobilization, manipulation, and adjusting of joints, joint capsules, and surrounding holding elements (muscles, ligaments, and tendons) of aberrant articulations can decrease the patients pain and increase range of motion. Literature and reference of all kinds for many years has contended, and research has proven that to relocate abnormal articulations and correct misalignment from biomechanical abnormalities creates an atmosphere of correction and recovery from which patients respond very well. The chiropractic profession, as well as the osteopathic profession, have long stood behind these practices, and the medical profession in most recent years have also given credence to mobilization and manipulation as a real alternative to other frequently used methods of medical pharmacologic intervention or surgery.

Manipulation under anesthesia is a modality which has been used by all of the above mentioned practitioners since the early 30's to bring about the correction of biomechanical abnormalities that would only respond minimally to conservative office based manual therapy in its various forms. The object and therefore the clinical justification for the use of MUA is simply to relax the patient and then make the corrections in the biomechanical abnormality by means of stretching mobilization and manipulation of the articulations that are involved in the abnormal mechanical alteration. If the right anesthesia is introduced in a proper environment that allows the patient to respond, but be less apprehensive and have less discomfort, the practitioner who has MUA certificate training is better able to make corrections such that the patient gains back range of motion and therefore is relieve of neurological stressors that cause painful response while they are being compressed. To make more out of this than this simple statement is complicating a very well received and very well used procedure that causes many recoveries that would not respond if not for this procedure being used.

Clinically we are basically taking arthrokinectic dysfunctional anatomy which is causing fibroblastic proliferative changes (adhesions) to be formed, altering them, and giving back normal movement and in the process decreasing pain and dysfunction.

Patient Selection Criteria

In conjunction with the National Academy of MUA Physicians and following their standards and protocols the following would be indicated but may not be limited to: Following the standards of proper care as outlined by the NAMUAP standards and protocols which calls for a minimum of 4-6 weeks of conservative manual therapy care:

1. The patient must exhibit pain and or muscle spasm/contracture documented by three of the following:
   a. Observation
   b. Palpation

c. Visual analog scale
d. Measurement (algometry)
e. History
f. Objective testing such as MRI, CT, EMG, Surface EMG, Mechanical Dermatomal alteration, or other well established diagnostic testing modalities.
g. Standardized pain questionnaire such as Oswestry or Roland Morris

2. The patient must also be diagnosed as having a primary neuromusculoskeletal complaint as the primary cause of the patients complaint using the standard MUA protocols for MUA patient selection criteria (NAMUAP).

3. The patient's diagnosed condition must interfere with the patient's **activities of daily living** as outlined in the history and physical, and fall within the standard **indications** for MUA, as referenced in: "Manipulation Under Anesthesia, Concepts In Theory and Application", R. Gordon, April 2005, Taylor and Francis, and the NAUMAP standards and protocols.

4. Sufficient care has been rendered prior to MUA selection as referenced above.

5. The patient has been informed of other treatments that might also be available, but has chosen to proceed with the MUA procedure after adequate explanation of the risks and benefits.

Medical Clearance and Standardized Review

Medical clearance is required for MUA just like medical clearance is required for any procedure completed under anesthesia. The requirements for medical clearance vary for each state, and each facility and the anesthesiologists requirements before anesthesia is provided. This determines what the standard testing will be required before the patient undergoes MUA. In general the class one patient will be required to have a physical examination involving all systems, heart, respiratory system, liver, abdomen, eyes nose and throat, and complete musculoskeletal and neurological work up. Blood work that is required is usually minimal (ex. SMAC 6) just to rule out any problems that might prevent excretion of medicines and slow metabolism etc.. Most facilities also require that the patients over 40-50 undergo an EKG, and if respiratory problems are suspected, or asthma, a chest x-ray. Since we only choose patients that fall within the class 1 or with evaluation class 2 anesthesia criteria, these tests are fairly routine in most facilities.

The other requirement is for medical supervision and oversight. Medical presence should be part of the team approach for MUA. It should be remembered that this not a one type of physician procedure. This is a team procedure and cannot be accomplished by one or even two practitioners. We teach in class that this is not a chiropractic procedure but rather a procedure that chiropractic physicians take part in. In order for this procedure to be completed there needs to be a medical clearance physician as mentioned above, there needs to be anesthesia clearance and an anesthesia practitioner involved, there needs to be medial oversight, there needs to be two

trained MUA practitioners to perform the procedure, and there needs to be nursing supervision of the patient during and after the procedure in recovery before the patient is sent home.

Treatment Protocols

1. The following must be considered when considering the treatment and the numbers of treatments necessary to achieve the desired results in the MUA field:

   a. Chronicity
   b. Length of current conservative therapy program
   c. Patients age
   d. Numbers of previous injuries to the same area
   e. Level of unimproved pain
   f. Patient acceptance
   g. Muscle contracture (beyond splinting)
   h. Interference with activities of daily living (ADLs)
   i. Augmentation of adhesion build up, esp. with failed back surgery
   j. Possible surgical intervention if MUA is not tried at this juncture of the patient's recovery. Serial MUA considered to prevent surgery where one procedure might still make the patient a surgical candidate, three or four MUAs might prevent the surgical intervention (ref. NAMUAP).

2. The usual and customary protocols for MUA have been to provide serial fashion MUA, where the procedure is repeated in three successive days. This approach over the years has proven to be very beneficial to the patient, and has been clinically justified by the referenced fact that when correcting adhesion build up, if collagen fibers are not addressed during remodeling in an intensive format, which is what MUA does, then adhesions (or fibroblastic proliferative tissue) begins to reform in 24-48 hours. It is the contention by the MUA community that if we were to allow for one MUA to be performed, and then waited a week to do another one etc., then the process of reformation and remodeling would not take place, but rather the adhesion would reform again. In doing that we would be constantly working to control the reformation of the adhesions that had formed over the period of time since the patient was injured. It has been shown doing MUA in serial fashion and based on the references that performing multiple MUAs and then following the MUAs with immediate post MUA care to be described later in these policies and procedures, that the adhesions do not form back as before as evidenced by the patient gaining considerable range of motion and decreased pain and in many cases an 80 to 90% recovery with the proper patient selection.

3. Post MUA Care – is without a doubt, one of the most important phases of the MUA procedure. With the fibroblastic proliferative tissues altered in an intensified manner, the joints, joint capsules, and the surround holding elements must undergo continuous motion and joint manipulation/adjusting to help reform those collagen fibers in order to maintain the status of improvement that was achieved during the MUA procedure. In the past, post care was carried on in a normal conservative fashion, however, it is now believed that immediate intensified post care consisting of immediate same day therapy using the exact

same stretches that were used during the MUA procedure, followed by 7-10 days of continuous motion, mobilization and manipulation with minimal resistance, followed by 2 weeks of pre-rehabilitation using slight to moderate resistive forces, and then 4 weeks of formal circuit training rehabilitation will give the best outcomes. This regime has been used over and over by the MUA community, and has been found to be the best approach to maintaining the improvement that was achieved during the MUA procedure itself. Since the end result of this procedure is recovery from the conditions that were chosen to receive the MUA procedure, and to maintain the status post recovery, the patient has to undergo changes in their life style, and feel a sense of accomplishment in not only the therapy that was administered using the MUA procedure, but in their own benefit by their participation in the recovery process.

Operative Procedure (this report is a guideline and sample for the full spine procedure referenced in the textbook, "Manipulation Under Anesthesia, Concepts In Theory and Application; R. Gordon....it is not meant to replace standard documentation specifically dictated for each procedure for each day the patient undergoes MUA.) Also note that extra spinal techniques have not been presented but should be dictated for each area treated.

PROCEDURES PERFORMED:

1. Manipulation of the hip joint requiring general anesthesia, **RIGHT & LEFT; CPT 27275 x 2 – 51**
2. Manipulation under anesthesia, shoulder joint, **RIGHT & LEFT; CPT 23700 x 2 – 51**
3. Manipulation of the spine requiring anesthesia, **CERVICAL, THORACIC, & LUMBAR regions; CPT 22505 x 3 – 51**

PRE-OP DIAGNOSIS: **(Example)**

1. Displacement of Thoracic and/or Lumbar IVD without Myelopathy **(ICD-9 722.1)**
2. Displacement of cervical IVD without Myelopathy **(ICD-9 722.0)**
3. Myalgia and Myositis; cervical, thoracic, lumbar, bilateral shoulder/peri-scapular musculature, pelvic girdle musculature, and bilateral hip regions **(ICD-9 729.1)**
4. Spasm of muscle/muscle hypertonicity; cervical, thoracic, lumbar, bilateral shoulder/peri-scapular musculature, pelvic girdle musculature, and bilateral hip regions **(ICD-9 728.85)**

POST-OP DIAGNOSIS:
Same as Pre-op Diagnosis

INFORMED CONSENT:
After adequate explanation of the medical, surgical, and procedural options, this patient has decided to proceed with the recommended spinal Manipulation Under Anesthesia. The patient has been informed that more than one procedure may be necessary to achieve satisfactory results.

INDICATION:
Upon review of the patient's history and supplied medical records the patient has been found a good candidate for manipulation under anesthesia. The standards of protocol being followed are set forth by the National Academy of MUA Physicians.

COMMENTS:
The patient understands the essence of the diagnosis and the reasons for MUA. The associated risks of the procedure, including anesthesia complications, fracture, vascular accident, disc herniation, and post-procedure discomfort, were thoroughly discussed with the patient. Alternatives to the procedure, including the course of the

condition without MUA were discussed. The patient understands the chances of success from undergoing MUA and that no guarantees are made or implied regarding outcome. The patient has given both verbal and written informed consent for the listed procedure.

THE PROCEDURE IN DETAIL:
The patient's pain level today was 8 out of a possible 10 (10 being the worst imaginable pain)
The patient was draped in appropriate gowning and was taken by gurney to the operative area and asked to lie supine on the operative table. The patient was then placed on the appropriate monitors for this procedure. When the patient and I were ready, the anesthesiologist administered the appropriate medications to assist the patient into twilight sedation using medications which allow the stretching, mobilization, and adjustments necessary for the completion of the outcome desired.

THE CERVICAL SPINE:
The patient's arms were crossed and the patient was approached from the rostral end of the table. Long axis traction was applied to the patient's cervical spine and musculature while counter-traction was applied by the co-attending doctor. The co-attending doctor was positioned to stabilize the patient's shoulders in order to use this counter-traction maneuver. Traction in the same manner was then applied into a controlled lateral coronal plane bilaterally, and then in an oblique manner by rotating the patient's head to 45 degrees and elevating the head toward the patient's chest. This was also accomplished bilaterally. At no time was the patient taken past the physiological barrier. The patient's head was then brought into a neutral posture and cervical flexion was achieved to traction the cervical paravertebral muscles. The cervical spine was then taken into a lateral traction maneuver to achieve specific closed reduction manipulation of vertebral elements at the cervical spine on the right side and again using the same technique on the left side of the cervical spine. During this maneuver, a low velocity thrust was achieved after taking the vertebrae slightly past the elastic barrier of resistance. Cavitations were achieved.

SHOULDER THORACIC LIFT:
With the patient in the supine position, the doctor distracts the right arm straight/superior cephalad to end range. This is accomplished on both sides to release thoracic elements before the thoracic adjustment.

SHOULDER:
With the patient in the supine position the doctor stands on the side of involvement. The doctor takes the patient's arm in the bent arm position and tractions up away from the patient's body and tucks the extremity into the doctor's abdominal area. The doctor has contact at the crook of the patient's bent arm and support contact on the patient's lateral shoulder area over the mid deltoid area. In this position, the attending doctor then walks the extremity forward into forward flexion noting range of motion and patient's resistance. Once the extremity and thus the shoulder was taken into forward flexion the next move was to leave the contact hand in place and do an adduction traction over the doctor's hand toward the middle of the patient' body. The next move was then to relocate position so that internal and external ranges of motion are performed. The attending doctor can take the shoulder through simple external and internal ranges of motion on the first day and then become more aggressive on the following days by contacting the upper extremity up near the axial and doing internal and external rotation closer to the body.

The next part of the procedure is the same forward flexion maneuver with the arm straight. Traction is accomplished by contacting the wrist, tucking the arm in close to the doctor, and then walking the arm forward into forward flexion. Then the same adduction move is accomplished with the doctor keeping the arm straight and tractioning the arm over his or her hand toward mid line of the body. Next the doctor stands at the head of the patient and lowers the patient's arm to his side. Forward flexion in then accomplished with a knife edge contact at the acromioclavicular humeral joint area. Traction is made during forward flexion into the knife edge and a slight thrust into the joint is made.

The attending doctor then assumes the forward position and tractions the arm up and away and at the same time rotates his hip into the axillary area. This opens up the joint space and the doctor contacts the lateral border of the clavicle and administers three short toggle thrusts into the area with a pisiform contact. The thrusts are not directed into the clavicle but the line of drive is more toward the lateral clavicle and the medial border of the humerus.

The patient is then placed in the side lying position and circumduction clockwise and counterclockwise is accomplished by contacting the head of the humerus. This maneuver is accomplished by the doctor cupping the hands with interwoven fingers around the head of the humerus and the movements are very small and deliberate.

Once all these maneuvers are accomplished the doctor then completes the A to P manipulative procedure. Contact is at the cephalad border of the pectoralis major with support for the scapula and at the anterior aspect of the humeral glenoid cavity joint. The thrust is a motion that mimics the relocation of the head of the humerus into the glenoid cavity. The movement is up and over the shoulder with respect to line of drive.

THE THORACIC SPINE:
With the patient in the supine position on the operative table, the upper extremities were flexed at the elbow and crossed over the patient's chest to achieve maximum traction to the patient's thoracic spine. The co-attending doctor held the patient's arms in the proper position and assisted in rolling the patient for the adjustive procedure. With the help of the first assistant, the patient was rolled onto their side, selection was made for the contact point and the patient was rolled back over the doctor's hand. The elastic barrier of the resistance was found, and a low velocity thrust was achieved using a specific closed reduction anterior to posterior manipulative procedure. This same procedure was repeated at the upper, middle, and lower thoracic regions.

MEDIAL SCAPULAR BORDER LIFT:
With the patient in the side lying position, the patient's lower arm is moved behind the patient to allow relaxation of the scapular muscles. With the assistance of the co-attending doctor, the attending doctor reaches into the medial scapular area and lifts both vertically and laterally to separate subscapular adhesions.

THE LUMBAR SPINE:
With the patient supine on the procedure table, the primary physician addressed the patient's lower extremities which were elevated alternatively in a straight leg raising manner to until resistance due to adhesions and/or nocioceptive response by the patient. Linear force is used to increase the hip flexion gradually during this maneuver. Simultaneously, the co-attending physician applies a myofacial release technique to the calf and posterior thigh musculature. Each lower extremity was independently bent at the knee and tractioned cephalad in a neutral sagittal plane, lateral oblique cephalad traction, and medial oblique cephalad traction maneuver. The primary physician then approximated the opposite single knee from their position from neutral to medial slightly beyond the elastic barrier of resistance, allowing for a piriformis myofascial release as well. This was repeated with the opposite lower extremity. Following this, a Patrick-Fabere maneuver was performed up to and slightly beyond the elastic barrier of resistance.

PIRIFORMIS BOW-STRING STRETCH:
With the patient in the supine posture and following the adductor stretch, the patient's knee is held slightly past medial and the attending doctor contacts the knee with their hand. The force is applied toward the table with the help of the co-attending doctor and the piriformis muscle is then massaged. The force down the femur into the pelvic basin allows for relaxation of the piriformis muscle across the obturator foramina.

With the co-attending physician stabilizing the pelvis and femoral head, the attending physician extended the right lower extremity in the saggital plane, and while applying controlled traction radically stretched the para-articular holding elements of the right hip by means of gradually describing an approximately 30-35 degree horizontal arc. The lower extremity was then traction straight caudad and internal rotation was accomplished. Using traction, the lower extremity was gradually stretched into a horizontal arch to approximately 30 degrees. This procedure was then repeated using external rotation to stretch the para-articular holding elements of the hips bilaterally. These procedures were then repeated on the opposite lower extremity.

With the patient's lower extremities kept in hip and knee flexion, the patient's torso was secured by the co-attending doctor and the lumbar fasciae and musculature elongated obliquely to the right of mid-line, in a controlled manner up to and beyond the elastic barrier of resistance. Cavitation was noted. This was repeated on the opposite side.

The patient is then repositioned in the supine posture and the same lateral knee movement is repeated bilaterally only this time there is more of a torsion traction movement up toward the head and then laterally away from the main trunk thereby stretching the lumbar holding elements of the spinal motion units. This posture is proving to

show potential disc decompression as evidenced by pre and post MRI studies that have been completed for research purposes.

With the use of under sheets, the patient was carefully placed in the side lying decubitus position and positioned so that the lumbar spine overlay the kidney plate to the point where the lumbar spine attained the horizontal and was de-rotated to avoid facet imbrications.

ILIOPSOAS STRETCH:
With the patient in the side lying position, the upper leg is bent at the knee and distracted in a horizontal manner to stretch the iliopsoas muscle. The leg is then extended more caudad at a 30 degree angle to stretch the TFL.

The patient's body was stabilized by the first assistant. The knee and hip of the upper leg were flexed and the lower leg stabilized in the extended position by the co-attending doctor. Segmental localization of the appropriate lumbar motion-units was made by the attending physician and the elastic barrier of resistance found. A low velocity impulse thrust was applied achieving cavitation. This procedure was then repeated for the sacroiliac joint. The posterior superior iliac spine and lumbar spine was then adjusted on the opposite side with the patient in the same position as above.

The patient was then repositioned supine by means of the under sheets. With appropriate assistance, the patient was transferred from the procedure table to the gurney and was returned to the recovery room, where appropriate monitoring equipment was utilized to monitor vital signs. The IV was maintained up to the point where the patient was fully alert and stable. The patient was then transferred to a sitting recovery position and given fluids and a light snack. Following this, the patient was discharged with appropriate home instructions.

COMPLICATIONS:
The patient tolerated the procedure well with no untoward incident or complication.

SUMMARY:
The patient tolerated the procedure well and without complications and recovered from the general anesthesia without difficulty.

SUMMARY:
The patient underwent MUA of the axial spine and extremities. The patient tolerated the procedure well; there were no intra-operative or post-operative complications. The patient was able to achieve increased motion post MUA without significant muscle guarding. With the improvement of range of motion, it is medically reasonable to opine that this patient's fibro-adhesive conditions were significantly impacted, increasing the potential for appropriate neuromuscular re-education of affected myofacial structures and before having re-establishment of collagen deposition during the healing phase.

PATIENT INSTRUCTIONS:
The patient will receive post MUA therapy in the doctor's office or P.T. suite to include heating the area of involvement; stretching of the involved areas just as they were stretched during the MUA procedure; followed by interferential in a hertz range of 80-120 and 0-10 with cryotherapy for a duration of no longer than 20 minutes. This will be completed each day after the MUA procedure.

PROGNOSIS:
The patient under went post MUA examination and considering the patient's overall improvement in function and diminishing pain, it is opined, absent further injury, that the patient's prognosis is considered to be good. The patient will continue with the next procedure based on the improvement noticed during the post examination and in keeping with the recommendations of the serial pattern of MUAs as per standing orders. This follows standards and protocols as established by the National Academy of MUA Physicians. The patient has been instructed that periodic exacerbations or remissions may be experienced. These may be adequately managed by means of palliative care and with the recommended post MUA therapy.

Recommendations For Pre and Post Instructions to The MUA Patient

Pre MUA Instructions:

The patient should get a good nights sleep; the patient needs to be NPO 8-12 hours before the procedure due to the administration of anesthesia; the patient should not eat a heavy meal the night before the procedure is completed the following day; medications that are taken normally are usually taken with a sip of water the morning of the procedure (these recommendations are determined by the anesthesiologist in charge of the procedure, i.e for hypertension etc.); the patient must have undergone a medical clearance for anesthesia by an MD or a DO who is familiar with the proccdure that is being performed so that an accurate opinion of the patient tolerating the anesthesia is obtained prior to undergoing MUA; the patient must have transportation other than themselves from the facility where the procedure is being performed back to their home. No one will be allowed to leave the facility without proper transportation; the patient should be out of work the days that the procedure is being administered. This procedure involves the administration of an anesthesia and the patient should not be signing anything important, making decisions, nor driving any vehicle while they are under the effects of the anesthesia which could affect them most of the day of the procedure.

Post MUA Instructions:

The post MUA instructions are based on what the treating physician wants the patient to do. However, the generalized post MUA instructions consist of returning to a semi-normal to normal diet. By this we mean that on the days of the MUA when a second or third MUA are completed the next day we recommend that a light diet be followed. Once the MUAs have been completed then the patient can return to their normal diet with recommendations from their treating physician. On the days of the procedure, we recommend that the patient be seen at the treating doctor's office later that same day if possible. With late afternoon MUA procedures being completed this is not practical, but when procedures are completed in the morning the patient should return to the office in the afternoon for post MUA care same day. We recommend that ice be used by the patient, and that they follow the instructions of the anesthesiologist, or medical treating doctor as far as post MUA medications. The patient should rest the days of the procedures, and should not being doing anything strenuous. Doing strenuous exercise or movements could cause harm to the patients until given permission to do these types of activities by their treating physician. Again, if the patient is going to undergo the next in a series of MUAs, the patient should be NPO 8-12 hours before the next days MUAs. Over the years we have not had any lingering effects from anesthesia when multiple MUAs are completed on three successive days.

Recommendations For Post MUA Therapy and Rehabilitation

The treating physician is ultimately responsible for the post MUA care. Our recommendation is that since we are attempting, and in most cases accomplishing the altering of adhesions (fibroblastic proliferative collagen tissue) from reforming in and about the joints and holding elements, that continued regular stretching should be started immediately after the MUAs. We recommend that if possible these stretches be the same as during the MUA procedure, and that

they be performed on the same day as the MUA with no manual adjustive therapy. Once the final MUA is completed, we recommend continuing with the stretching process that has already begun, but that now the adjustive techniques also be added. This process should ideally be performed on a daily basis for 7-10 days following the MUA procedures. We then recommend 2 weeks of pre-rehabilitation which would involve the beginning of continued movement with slight resistive strengthening. This is still not the time for conditioning and strengthening, but a time for the patient to start rebuilding the strength that was lost from injury, and from the process of the MUA procedure where weakening occurs as part of the corrections that take place as a result of performing this procedure. This is then followed by between 4 and 6 weeks of formal rehabilitation. It is this part of the post recovery phase of MUA where the patient claims his or her recovery and strengthens the body to return to their normal pre-injury physical capacity and activities of daily living. We recommend circuit training which not only helps the patient regain strength, but is also enjoyable to accomplish. Encouragement for re-strengthening should be foremost on the treating physicians mind at this point so that the patient will want to continue with their fitness program when they are dismissed from formal treatment.

Service Area
Hospital - Pain Management

2009	Co.	I/P	O/P
Centennial Medical Ctr.	Davidson	0	100
St. Thomas Hospital	Davidson	0	0
Skyline Madison Campus	Davidson	13	1,008
Southern Hills Medical Ctr.	Davidson	0	13
Summit Medical Ctr.	Davidson	0	0
Vanderbilt Stallworth Rehab.	Davidson	3	0
Vanderblilt University Hospital	Davidson	25	909
NorthCrest Medical Ctr.	Robertson	0	0
Middle TN Medical Ctr.	Rutherford	0	0
StoneCrest Medical Ctr.	Rutherford	1	66
Total		42	2,096

2010	Co.	I/P	O/P
Centennial Medical Ctr.	Davidson	75	429
St. Thomas Hospital	Davidson	0	0
Skyline Madison Campus	Davidson	7	785
Southern Hills Medical Ctr.	Davidson	0	33
Summit Medical Ctr.	Davidson	0	0
Vanderbilt Stallworth Rehab.	Davidson	0	0
Vanderblilt University Hospital	Davidson	7	1,096
NorthCrest Medical Ctr.	Robertson	0	0
Middle TN Medical Ctr.	Rutherford	0	0
StoneCrest Medical Ctr.	Rutherford	6	162
Total		95	2,505

2011	Co.	I/P	O/P
Centennial Medical Ctr.	Davidson	42	317
St. Thomas Hospital	Davidson	0	24
Skyline Madison Campus	Davidson	0	530
Southern Hills Medical Ctr.	Davidson	0	18
Summit Medical Ctr.	Davidson	0	3
Vanderbilt Stallworth Rehab.	Davidson	0	0
Vanderblilt University Hospital	Davidson	4	1,530
NorthCrest Medical Ctr.	Robertson	0	67
Middle TN Medical Ctr.	Rutherford	0	1
StoneCrest Medical Ctr.	Rutherford	22	433
Total		68	2,923

Source: 2009, 2010 & 2011 JAR, Schedule D - Services

Service Area ASTC's
Pain Management

2010	Co.	ORs	PR	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,077	7,472	14.4%	2,208	12,709	17.4%	1,816
Baptist Plaza Surgicare	Davidson	9	1	10	942	9,427	10.0%	2,619	23,104	11.3%	2,310
Centennial Surgery Ctr	Davidson	6	2	8	1,116	7,217	15.5%	2,930	13,403	21.9%	1,675
Northridge Surgery Ctr	Davidson	4	1	5	654	3,673	17.8%	1,782	9,599	18.6%	1,920
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	681	2,104	32.4%	1,746	4,377	39.9%	2,189
Premier Radiology Pain Management Ctr	Davidson	0	2	2	1,666	1,666	100.0%	5,839	5,839	100.0%	2,920
St. Thomas Campus Surgicare	Davidson	6	1	7	1,459	6,835	21.3%	6,122	19,479	31.4%	2,783
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	2	4	2,523	2,523	100.0%	5,481	5,481	100.0%	1,370
Summit Surgery Ctr	Davidson	5	1	6	2,267	6,873	33.0%	4,764	13,277	35.9%	2,213
Tennessee Pain Surgery Ctr	Davidson	1	3	4	2,305	2,305	100.0%	7,294	7,294	100.0%	1,824
Middle Tennessee ASTC	Rutherford	6	1	7	437	6,244	7.0%	1,465	12,607	11.6%	1,801
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	922	3,243	28.4%	2,101	6,561	32.0%	1,312
Surgicenter of Murfreesboro Med. Clinic	Rutherford	4	3	7	9	7,468	0.1%	153	10,124	1.5%	1,446
Cool Springs Surgery Ctr	Williamson	5	1	6	233	6,790	3.4%	493	11,114	4.4%	1,852
Crossroads Surgery Ctr	Williamson	0	1	1	220	220	100.0%	500	500	100.0%	500
Williamson Surgery Ctr	Williamson	4	1	5	1	3,531	0.0%	1	4,417	0.0%	883
Total		64	22	86	16,512	77,591	21.3%	45,498	159,885	28.5%	1,859

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2010 JAR, Schedule D - Availability and Utilization of Service

Service Area ASTC's
Pain Management

2011	Co.	ORs	PR	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,098	7,304	15.0%	2,352	16,059	14.6%	2,294
Baptist Plaza Surgicare	Davidson	9	1	10	568	9,171	6.2%	1,161	21,635	5.4%	2,164
Centennial Surgery Ctr	Davidson	6	2	8	1,556	7,405	21.0%	3,625	13,486	26.9%	1,686
Northridge Surgery Ctr	Davidson	4	2	6	273	3,201	8.5%	8,318	16,416	50.7%	2,736
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	974	2,382	40.9%	2,400	5,122	46.9%	2,561
Premier Radiology Pain Management Ctr	Davidson	0	2	2	2,000	2,000	100.0%	6,701	6,701	100.0%	3,351
St. Thomas Campus Surgicare	Davidson	6	1	7	1,721	7,639	22.5%	6,439	25,441	25.3%	3,634
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	1	3	2,469	2,469	100.0%	5,544	5,544	100.0%	1,848
Summit Surgery Ctr	Davidson	5	1	6	1,672	6,505	25.7%	4,306	14,112	30.5%	2,352
Tennessee Pain Surgery Ctr	Davidson	1	3	4	3,316	3,316	100.0%	7,848	7,848	100.0%	1,962
Middle Tennessee ASTC	Rutherford	6	1	7	464	6,264	7.4%	1,570	12,644	12.4%	1,806
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	752	2,976	25.3%	1,616	5,781	28.0%	1,156
Surgicenter of Murfreesboro Med. Clinic	Rutherford	*	*	*	*	*	*	*	*	*	*
Cool Springs Surgery Ctr	Williamson	5	1	6	12	6,501	0.2%	26	10,841	0.2%	1,807
Crossroads Surgery Ctr	Williamson	0	1	1	275	275	100.0%	720	720	100.0%	720
Williamson Surgery Ctr	Williamson	4	1	5	6	3,410	0.2%	6	6,443	0.1%	1,289
Total		60	19	79	17,156	70,818	24.2%	52,632	168,793	31.2%	2,137

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
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Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2011 JAR, Schedule D - Availability and Utilization of Service

Service Area ASTC's
Pain Management

2012 - Provisional	Co.	ORs	PR	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,178	7,443	15.8%	2,485	15,599	15.9%	2,228
Baptist Plaza Surgicare	Davidson	9	1	10	340	8,215	4.1%	691	17,641	3.9%	1,764
Centennial Surgery Ctr	Davidson	6	2	8	1,569	7,491	20.9%	3,430	13,914	24.7%	1,739
Northridge Surgery Ctr	Davidson	5	2	7	296	2,863	10.3%	652	6,928	9.4%	990
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	143	2,277	6.3%	287	4,443	6.5%	2,222
Premier Radiology Pain Management Ctr	Davidson	0	2	2	1,957	1,957	100.0%	6,327	6,327	100.0%	3,164
St. Thomas Campus Surgicare	Davidson	6	1	7	1,624	7,446	21.8%	3,589	17,910	20.0%	2,559
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	1	3	2,530	2,530	100.0%	5,465	5,465	100.0%	1,822
Summit Surgery Ctr	Davidson	5	1	6	1,057	5,445	19.4%	2,313	12,534	18.5%	2,089
Tennessee Pain Surgery Ctr	Davidson	1	3	4	2,847	2,847	100.0%	8,960	8,960	100.0%	2,240
Middle Tennessee ASTC	Rutherford	6	1	7	597	6,490	9.2%	1,918	12,708	15.1%	1,815
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	833	2,864	29.1%	1,861	5,314	35.0%	1,063
Surgicenter of Murfreesboro Med. Clinic	Rutherford	*	*	*	*	*	*	*	*	*	*
ASTC of Cool Springs	Williamson	5	1	6	370	7,292	5.1%	785	11,066	7.1%	1,844
Crossroads Surgery Ctr	Williamson	0	2	2	432	432	100.0%	4,419	4,419	100.0%	2,210
Williamson Surgery Ctr	Williamson	*	*	*	*	*	*	*	*	*	*
Total		57	19	76	15,773	65,592	24.0%	43,182	143,228	30.1%	1,885

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2012 Provisional JAR, Schedule D - Availability and Utilization of Service

Attachment C.N.5.B

Service Area ASTC's
Pain Management Charges

2010	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,179,983	$2,163,383	1,666	$1,909	$1,299	2,751	$1,156	$786
St. Thomas Outpatient Neurosurgical	Davidson	$5,849,686	$2,615,321	2,523	$2,319	$1,037	2,523	$2,319	$1,037
Tennessee Pain Surgery	Davidson	$14,277,365	$3,072,102	2,305	$6,194	$1,333	7,294	$1,957	$421
Crossroads Surgery	Williamson	$590,000	$207,350	220	$2,682	$943	500	$1,180	$415
Total		$23,897,034	$8,058,156	6,714	$3,559	$1,200	13,068	$1,829	$617

2011	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,680,792	$1,184,882	$2,000	$1,840	$592	3,282	$1,122	$361
St. Thomas Outpatient Neurosurgical	Davidson	$5,811,928	$2,473,977	$2,469	$2,354	$1,002	5,544	$1,048	$446
Tennessee Pain Surgery	Davidson	$13,137,957	$5,378,167	$3,316	$3,962	$1,622	7,848	$1,674	$685
Crossroads Surgery	Williamson	$331,500	$103,089	$116	$2,858	$889	1,560	$213	$66
Total		$22,962,177	$9,140,115	$7,901	$2,906	$1,157	18,234	$1,259	$501

2012 - Provisional	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$6,171,671	$1,520,976	1,957	$3,154	$777	3,196	$1,931	$476
St. Thomas Outpatient Neurosurgical	Davidson	$5,457,807	$2,291,681	2,530	$2,157	$906	5,465	$999	$419
Tennessee Pain Surgery	Davidson	$14,637,835	$5,604,720	2,847	$5,141	$1,969	8,960	$1,634	$626
Crossroads Surgery	Williamson	$1,518,879	$286,422	432	$3,516	$663	4,419	$344	$65
Total		$27,786,192	$9,703,799	7,766	$3,578	$1,250	22,040	$1,261	$440

Source: 2010,2012 & 2012(Provisional) JAR, Schedule D - Availability and Utilization of Service & Schedule F - Finacial Data

Attachment C.N.5.C

3:29 PM
02/06/13
Accrual Basis

MUA OF MIDDLE TENNESSEE LLC
Balance Sheet
As of December 31, 2012

	Dec 31, 12
ASSETS	
Current Assets	
Checking/Savings	
102 · First Farmers - Checking	506.56
103 · First Tennessee Bank	13,228.02
Total Checking/Savings	13,734.58
Other Current Assets	
140 · A/R Trade	304,457.37
141 · Less Allowance for Discounts	-219,209.31
Total Other Current Assets	85,248.06
Total Current Assets	98,982.64
Fixed Assets	
150 · Furniture and Fixtures	14,130.12
155 · Machinery and Equipment	128,669.00
157 · Leasehold Improvements	82,859.00
161 · Accumulated Depreciation	-153,798.00
Total Fixed Assets	71,860.12
TOTAL ASSETS	170,842.76
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
208 · Note Payable - A. Douglas Lensg	48,113.25
209 · Note Payable - Faye Smith	3,500.00
210 · Note Payable - Tn Spine	63,382.67
Total Other Current Liabilities	114,995.92
Total Current Liabilities	114,995.92
Total Liabilities	114,995.92
Equity	
304 · Terry Totty - Equity	24,401.99
306 · Lance Benedict - Equity	24,401.98
310 · Paul Yim - Equity	200,000.00
312 · Brett Babat - Equity	100,000.00
320 · Retained Earnings	-158,822.69
Net Income	-134,134.44
Total Equity	55,846.84
TOTAL LIABILITIES & EQUITY	170,842.76

T6

3:29 PM
02/06/13
Accrual Basis

MUA OF MIDDLE TENNESSEE LLC
Profit & Loss
January through December 2012

	Jan - Dec 12
Ordinary Income/Expense	
Income	
350 · Fee for Service Income	779,273.42
352 · Returns and allowances	-200.00
353 · Less Contractual Discounts	-631,643.35
Total Income	147,430.07
Expense	
420 · Medical Records and Supplies	3,571.35
450 · Medical Safety Inspection	382.38
500 · Subcontractor	1,761.00
610 · Automobile Expense	1,055.00
612 · Background Verification	313.95
615 · Bank and Credit Card Charges	1,815.30
620 · Continuing Education	2,975.00
623 · Computer expenses	2,371.92
630 · Depreciation Expense	44,031.00
632 · Design/Planning	28,688.00
633 · EHR Support	7,922.47
635 · Janitorial Expense	1,920.00
638 · Employee Expense	84.93
639 · Insurance Expense	
640 · General Liability	500.00
643 · Malpractice	2,531.53
Total 639 · Insurance Expense	3,031.53
660 · Professional Fees	8,743.24
670 · Office Supplies	1,262.67
675 · Payroll Expenses	
676 · Office Employee	35,901.63
675 · Payroll Expenses - Other	37,196.60
Total 676 · Payroll Expenses	73,098.23
680 · Rent Expense	
681 · Rent - Building	20,966.22
682 · Rent - Equipment	29,485.00
680 · Rent Expense - Other	45,272.45
Total 680 · Rent Expense	85,723.67
705 · Taxes and Licenses	2,275.00
710 · Telephone Expense	537.87
Total Expense	281,564.51
Net Ordinary Income	-134,134.44
Net Income	-134,134.44

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
WEST TENNESSEE REGIONAL OFFICE
2975 Highway 45 Bypass, Suite C
Jackson, Tennessee 38305
Telephone: (731) 984-9684
Fax: (731) 512-0063

March 06, 2012

Ms. Faye Smith, Administrator
MUA of Middle Tennessee, LLC
28 White Bridge Road, Suite 210
Nashville, TN 37205

RE: Initial Licensure Survey

Dear Ms. Smith:

The West Tennessee Regional Office of Health Care Facilities conducted an initial state licensure survey at your facility **February 07, 2012.** We are pleased to inform you that **no deficiencies were cited** on the survey. A copy of the results is enclosed for your records.

Thank you for your cooperation shown during the survey. If we may be of assistance to you, please do not hesitate to call.

Sincerely,

Diane Carter/RN

Diane Carter, RN, LNCC
Public Health Nurse Consultant II

PDC/rm

Enclosure

PUBLIC CHAPTER NO. 0817

This public chapter amends T.C.A. Titles 38, 39, 63, and 68 to require health care providers to report injuries appearing to result from female genital mutilation. Effective 7/1/12.

PUBLIC CHAPTER NO. 0915

This public chapter amends Titles 39, 53, 63, and 71 to authorize hospital quality improvement committees to access the controlled substances database if suspect an employee of self-prescribing medications. Effective 6/12/12.

PUBLIC CHAPTER NO. 0916

This public chapter amends T.C.A. Titles 63 and 68 enacting the "The Henry Granju Act", to create reporting requirements by provider and Medical Examiners relate to drug overdoses. Effective 5/10/12.

PUBLIC CHAPTER NO. 1008

This public chapter amends T.C.A. Titles 37 and 39 and Title 38, Chapter 11 prohibiting physicians from performing abortions without admitting privileges at a local hospital. In addition, the public chapter requires physicians to notify patient of where the physician has privileges. It also requires a monthly report to the Tennessee Department of Health of each abortion by the facility and where the abortion was performed and signed by the physician who performed the abortion. The public chapter requires the Tennessee Department of Health to annually report to the General Assembly aggregate data from the monthly reports. The public chapter stipulates report requirements. It also requires, in addition to other penalties, that any person, organization or facility convicted of willfully violating any of the provisions of this section to have its license suspended for six months for the first violation, one year for the second violation, and revoked for the third violation. Effective 7/1/12.

PUBLIC CHAPTER NO. 1093

This public chapter amends T.C.A. Titles 36 and 38 which removes the requirement that providers report certain injuries to law enforcement if victim objects. Effective 5/21/12.

DISCIPLINARY ACTION 2012

The board took action against the following licensed health care facilities:

FEBRUARY 2012

Licensee: East Tennessee Health Care Center, Madisonville – nursing home
Violation: Deficiencies cited rising to the level of a Type A civil penalty
Action: Assessment of civil penalty in the amount of $3,600.00 and suspension of admissions

MARCH 2012

Licensee: Bristol Nursing Home, Bristol – nursing home
Violation: Deficiencies cited rising to the level of a Type A civil penalty
Action: Assessment of civil penalty in the amount of $2,700.00 and suspension of admissions

MAY 2012

Licensee: Schilling Gardens, Collierville – assisted care living facility
Violation: Deficiencies cited rising to the level of civil penalty imposition
Action: Assessment of civil penalty in the amount of $2,000.00

Licensee: Kennington Pointe, Memphis – assisted care living facility
Violation: Deficiencies cited rising to the level of civil penalty imposition
Action: Assessment of civil penalty in the amount of $7,500.00

DEFICIENCY FREE SURVEYS

FEBRUARY 2012

AMBULATORY SURGICAL TREATMENT CENTER PROVIDERS:
MUA of Middle Tennessee, LLC
Physician's Surgery Center of Chattanooga

HOME MEDICAL EQUIPMENT PROVIDERS:
Advanced Diabetic Solutions
Medical Necessities, Inc.
Advantage Healthcare
American Home Patient, Inc.
American Oxygen Home Care
Anderson Drugs & Home Care Center
Bradley Medical Equipment
Carr Rehab, Inc.
Cherokee Medical Supply
Convalescent Supplies
Little Drugs
Lookout Medical Services, Inc.
Nutritional Support Services
Ophello Medical Equipment
Oxygen & Sleep Associates
RGH Enterprises, Inc.
Specialty Oxygen Service, Inc.
Tri-State Respiratory Service, Inc.

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

September 17, 2012

Organization #:	98360
Organization:	**MUA of Middle Tennessee, LLC**
Address:	**28 White Bridge Road, Suite 210**
City, State, Zip:	**Nashville, TN 37205**
Decision Recipient:	**Deanna Smith**
Survey Date:	**August 7, 2012**

Type of Survey: **Early Option Survey**

Survey Chairperson: **Marjorie E. Vincent, RN, MBA, CASC**

Accreditation Term Begins: **August 7, 2012** **Accreditation Term Expires:** **August 7, 2015**

Plan for Improvement Submitted: August 29, 2012
Interim Survey by Date: August 7, 2013 Interim Survey Type: Full Survey

Scheduling Coordinator: Leah Peters

Accreditation Renewal Code: **11756bd498360**

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement. Since your organization was required to submit a plan for improvement, receipt of this letter denotes acceptance of the plan for improvement. Your organization is required to undergo an interim survey so that AAAHC may monitor compliance with the Accreditation Standards.

In accordance with AAAHC requirements, your organization has submitted a Plan for Improvement that describes any follow-up or corrective action taken by your organization following the most recent on-site survey. As stated in the current *Accreditation Handbook*,

> An interim survey will be conducted when the AAAHC determines that an on-site visit is necessary to review the organization's implementation of the PFI. The organization will be notified of the time frame for the interim survey to occur after the accreditation survey. Following the interim survey, the organization's accreditation term may be maintained, reduced, or revoked.
>
> Organizations electing an Early Option Survey (EOS) are eligible to receive a three-year term of accreditation; however, the organization must undergo an interim survey to assess the organization's continued compliance with the accreditation Standards. The interim survey will not be limited to a review of the deficiencies noted in the previous survey report; all core and applicable adjunct Standards will be reviewed.

Your organization will be contacted by the Scheduling Coordinator, who will work with your organization to confirm the surveyor(s) and dates of survey. Continuance of the current term of accreditation is contingent upon successful and timely completion of this survey.

AAAHC will be paying particular attention to the following:

- Adherence to the corrective actions indicated in the Plan for Improvement
- Mechanisms to prevent the reoccurrence of the deficiencies cited in the most recent survey
- For organization surveyed under the Early Option Survey Program, AAAHC will conduct a full survey to assess the continued implementation of all policies and processes for continued maintenance with the accreditation Standards.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Improving Health Care Quality Through Accreditation
5250 Old Orchard Road, SUITE 200
Skokie, Illinois 60077
TEL (847) 853 6060
FAX (847) 853 9028
www.aaahc.org
info@aaahc.org

PREMIER ORTHOPAEDICS
& SPORTS MEDICINE, PLC

Skyline Care Center
3443 Dickerson Pike
Suite 190
Nashville, TN 37207
Telephone (615) 860-1580
Fax (615) 860-1541

www.premier-ortho.com

Lawrence Brett Babat, M.D. will admit patients for Jay Parekh, D.O.

L. Brett Babat, M.D.

Public Notices

0101675156
NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205, owned and managed by itself, intends to file an application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $700,000.00.

The anticipated date of filing the application is: August 15, 2013.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at: 2021 Richard Jones Road, Suite 350, Nashville, Tennessee, 37215, 615/370-3380.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Frost Building
161 Rosa L. Parks Blvd., 3rd Floor
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

NOTICE OF PUBLIC AUCTION

Area Locator Map for Garage Sales & Real Estate

1. Murfreesboro Road to I-65
2. I-65 to Charlotte Pike
3. Charlotte Pike to Cumberland River West
4. Cumberland River West to Clarksville Pike
5. Clarksville Pike to Dickerson Pike
6. Dickerson Pike to Cumberland River East- Madison
7. Cumberland River East to I-40 Donelson-Lebanon Road
8. I-40 to Murfreesboro Rd.-Percy Priest Lake-Airport
9. Sumner County-Hendersonville, Gallatin, Old Hickory Boulevard
10. Williamson County-Franklin, Brentwood, Fairview
11. Wilson County-Lebanon, Mt. Juliet
13. Cheatham County
14. Robertson County
15. Dickson County
16. Maury County-Spring Hill, Columbia
18. Marshall County-Lewisburg, Chapel Hill
21 22 Rutherford County-Murfreesboro, Smyrna, La Vergne
23 27 Montgomery County-Clarksville, Ft. Campbell

Duplexes | Homes For Rent | Homes For Rent | Real Estate Commercial | Land/Farms - Cheatham Co.

ANTIOCH

bargains under $50

To place a FREE ad for an item under $50, call 242-SALE.
The categories listed below also can be found, with additional items, elsewhere in the Classifieds.

Antiques | Collectibles | Lawn/Garden | Misc. Merchandise

stuff

garage sales

Garage Sales

ESTATE SALE

MOVING SALE

Multi-Family

COPY-

SUPPLEMENTAL-1

MUA of Middle Tennessee, LLC

CN1308-031

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

SEP 30'13 11:1

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: MUA of Middle Tennessee, LLC (CN1308-031)

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr. Attorney at Law
Signature/Title

Sworn to and subscribed before me, a Notary Public, this 30th day of September, 2013; witness my hand at office in the County of Davidson, State of Tennessee.

Nadean E. Poteet
NOTARY PUBLIC
My Commission expires July 3, 2017

NADEAN E. POTEET
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

1. **Section A, Item 6**

   Are there any members of MUA of Middle Tennessee, LLC who are affiliated with Tennessee Spine and Nerve Institute, Inc.? Please discuss.

Drs. Terry Totty and Lance Benedict, who own 50% of MUA of Middle Tennessee, also own Tennessee Spine and Nerve Institute. Drs. Odell andYim and Mr. Goorevich all have ownership interests in MUA of Middle Tennessee, but have no ownership interest in, or any affiliation with, Tennessee Spine and Nerve Institute.

2. Section A, Item 12

Please indicate if there have been any discussions by the applicant with any TennCare MCO's regarding contracting for this proposed project. If so, what is the stage of discussion?

We have a contract with Amerigroup to provide services for interventional pain procedures in the MUA of Middle Tennessee Surgery center. We are currently negotiating with Americhoice to get a contract for these services as well.

3. Section B, Project Description, Item I

Please explain why the applicant chose to file this application rather than request an Agency determination regarding whether MUJA fell under the umbrella of MUA.

We were advised by the HSDA that needed to file a new CON in order to perform any type of injections in the surgery center.

Please provide a brief description of the service area, need and funding for the proposed project.

As stated, our service area is the same as our original MUA application, and consists of Davidson, Williamson, Rutherford, and Robertson Counties, which counties reflect patient origin (in number order) for 98% of the patients of Tennessee Spine and Nerve Institute, Inc. See *Attachment C.N.3* for a map of the proposed service area.

It is important to note that the service area for this project is based, in large part, on the actual patient origin information for two of the member/owners of the Applicant. Drs. Benedict and Totty currently serve patients from about 7 Middle Tennessee Counties, and the four top counties, in order of number of patients, are: Davidson, Williamson, Rutherford and Robertson Counties.

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. Manipulation under Anesthesia ("MUA") is such a procedure, and the Applicant is already approved for this service.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the early 1930s. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

The Applicant is forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. These measures include interventional pain management services such as joint injections. The HSDA originally determined that such procedures were included under MUA, and the Applicant provided such procedures for some time. Later, the HSDA determined that the Applicant is not approved for such interventional pain management services. Since the Applicant cannot conduct the MUA procedures for which it has already been approved without attempting interventional pain management procedures first, this application is being filed.

This Application includes administrative costs, and a relatively small amount for equipment, only (already purchased), and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved. Cash reserves have been utilized to pay for these nominal costs.

The applicant states they are forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. Please provide any documentation in the form of correspondence, policies and procedures, provider manuals, clinical criteria, etc. from insurance companies that support this statement.

Please see attachments *UHC-MUA Policy* and *BCBST-MUA*.

Since the applicant will only be performing interventional pain management services, has the applicant requested and received any waivers from the Tennessee Department of Health, Board of Healthcare Licensing Facilities regarding operating rooms?

Our facility procedure room was built to operating room codes for MAC sedation as a result of our original MUA application. When our existing ASTC was approved, we obtained minimal waivers, such as no requirement for an electrical generator, since we were not performing traditional surgery, but were performing manual procedures. We do not anticipate further waivers as a result of this application.

There appears to be an existing state registered licensed pain management clinic at the applicant's address. Please clarify the applicant's relation to that clinic and if the proposed project will be registered separately with the State of Tennessee as a registered pain clinic.

The address for MUA of Middle Tennessee, LLC (our ASTC) is Suite 210. Tennessee Spine and Nerve Institute, a licensed pain management facility, is Suite 208. The ASTC will be performing services for the patients of Tennessee Spine and Nerve. This CON application is for interventional pain procedures. MUA of Middle Tennessee, LLC will not be a registered pain clinic, as there will be no narcotics scripted out of the surgery center.

Will all patients having a pain management injection also receive a MUA procedure or are there occasions where a patient will have a pain management procedure and no MUA procedure or occasions where a patient will have no pain management procedure but receive a MUA procedure? If these several scenarios are possible please breakout the expected percentage of patients that will fall into each category.

MUA procedures and interventional pain management procedures will not be performed at the same time on the same patient. If interventional pain management is not successful, a patient may undergo traditional MUA treatment later. As we are required (by insurers) to attempt interventional pain management procedures first, we do not anticipate attempting such procedures on patients who have had the more traditional MUA procedure. However, it is important to note that we will attempt to alleviate pain in all of our patients with whatever means for which we are approved, based on their respective needs at any given time.

On page 9 of the application the applicant lists the Medicare and TennCare revenue projections. However, what is listed is the percentage of patients not the percentage of revenue. Please clarify.

We listed the percentage of patients, as this is the estimated percentage that will be referred for procedures in the surgery center. The percentage of revenue from Medicare is less than

commercial, and the percentage of revenue from Medicaid is less than both. As a practical matter, it is almost impossible to predict the exact amount of revenue from each payor source. Instead, it is our understanding that applicants normally multiply the gross revenue, deductions, and net revenue projections by the respective percentages of patients. Hence, Medicare revenue would likely approach $1,858,790 (Gross revenue of $4,646,975 x 40% = $1,858,790).

Likewise, it is anticipated that the impact on Medicaid will be $139,410 (Gross revenue of $4,646,975 x 10% x 30% State Share = $139,410).

Are interventional pain management procedures being performed now by the applicant or affiliated entity in an office setting at 28 White Bride Road, Nashville (Davidson County), TN 37909?

It is important to note that many pain management procedures can be performed in a physician's office. Currently, our pain boarded anesthesiologist is doing most spine injection procedures in the surgery center. He uses sedation for a lot of procedures and prefers the safer environment. He does do some pain management injections in the office of Tennessee Spine and Nerve.

4. Section B, Project Description, Item II A

Please clarify if the applicant is describing the development of the proposal since the project appears to not have any renovation or construction cost.

As stated, all costs for this project are administrative costs, only. This application is for a new service at an existing ASTC. There is no renovation or construction cost associated with this application.

5. Section C, Need Item 1

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan."

The State Health Plan's Five Principles for Achieving Better Health were written to initiate a dialogue as to how the State of Tennessee can improve its state health ranking.

We will address each principle and how MUA of Middle Tennessee relates to it by expanding the services to include interventional pain procedures.

Under **Principle Number One, Healthy Lives**, the top three health conditions in the State of Tennessee in order were:
1) 79% Obesity and Overweight,
2) 71% Heart attack, stroke, high blood pressure, and cardiovascular disease and
3) 63% Diabetes.

In addition, alcoholism and drug abuse were also found to be of importance. When a patient has chronic pain, without any education or relief of pain, the odds of improving his/her health are low. Treating their pain in the most efficacious and safe manner while educating them on a healthier lifestyle with the condition they have will improve their overall health. One of the primary objectives in increasing the services of MUA of Middle Tennessee is to improve the safety of patients who are in need of pain procedures. Many, if not most, patients who have chronic pain and are in need of interventional pain procedures have numerous co-morbidities, as noted above.

The adherence to the strict guidelines by CMS and our accreditation organization, AAAHC, which establishes the policies and procedures required for the appropriate surgery center environment, is our basis for patient care. In addition, the surgery center staff and physicians who have followed the patient from their initial visit have intimate knowledge of all of the patient's health problems, which will lessen the odds of an adverse event occurring during a procedure. Finally, it is and always has been our goal to decrease the amount of drug abuse, both prescription and illegal, in our patient population. No medications will be scripted in the surgery center setting.

Principle Number Two ,Access to Care, has been increased by MUA of Middle Tennessee by having a contract with Amerigroup. We are also working diligently on getting a contract with Americhoice, the other Medicaid providers in Middle Tennessee. We are credentialed with Medicare and most major commercial insurers. Also, as you may be aware, it is this patient population which has a higher incidence of prescription drug abuse, as well as co-morbidities. Being able to see these patients in a surgery center setting, provides a higher level of safety and decreases narcotic abuse.

One of the top ideas for improving **Principle Number Three, Economic Efficiency**, was to emphasize prevention in health care services. All patients who would receive procedures at MUA of Middle Tennessee would be required to have a one-on-one meeting with the physical medicine department of Tennessee Spine and Nerve Institute. A doctor of chiropractic medicine reviews diagnostics with each patient and goes over their particular health problems, and then structures a physical medicine approach for the individual patient. This could include nutritional counseling, physical therapy, chiropractic care, and manipulation under anesthesia, to basic exercise appropriate to the patient. This multi-discipline approach has been done throughout the

country with great efficacy and results. Our goal is to have all patients accept accountability for their individual health. We believe we will have higher quality outcomes of the procedures performed in the surgery center if we are able to establish this accountable thought process in the patient, through education.

Due to the higher standards surgery centers are held to, **Principle Four, Quality of Care**, is easily established. MUA of Middle Tennessee meets the definition of "high quality care" under this principle. Having a licensed and boarded pain medical doctor with a staff that is familiar with the patients and is specifically trained, and follow the required strict policies and procedures, creates the atmosphere for an effective, patient-centered, timely, efficient and equitable surgery center.

In addition "Patient Centered Care" is one of the big reasons we decided to have a surgery center in the first place. All of our healthcare providers, from the MD's, the physician extenders, chiropractors, therapists, and all support staff, partner with each other and the patient to establish the best possible care with the primary goal being great outcomes. We believe that having access to our own surgery center with providers who are familiar with the "whole patient" performing the procedures, is an improvement in the quality of care.

We believe increasing the services of MUA of Middle Tennessee to include interventional pain procedures relates to **Principle Five, Health Care Workforce** by having the existence of a comprehensive approach to pain treatment not based on medications. A pain-boarded physician performing procedures in the surgery center is the leader of the multi-disciplinary team who will examine, educate and treat the patient under the strict policies and procedures approved by the Governing Body of MUA of Middle Tennessee.

6. **Section C, Need, Item 1.a., Service Specific Criteria-ASTC (Item 1) and Section C. Need, Item 6**

The applicant projects 3,455 and 4,442 interventional pain management procedures in Year One and Year Two.

Is it possible for a patient to have more than one pain management procedure per visit? If yes, please provide the projected utilization based on patient visits/cases, since ASTC utilization standards are now based on cases.

Our pain anesthesiologist will not perform more than one pain management procedure per visit.

Please explain how procedures based on historical utilization were determined. Is it based on the MUJA procedures performed prior to the HSDA ruling? Please provide the details of the methodology used.

Procedures were not entirely based on MUJA procedures performed prior to the HSDA ruling. The surgery center was not seeing patients until September of 2012 as we were not entirely credentialed until the end of August 2012. At that point, we started very slowly doing MUJA one day per week and MUA for the full three days if a patient qualified. Our pain anesthesiologist determined he could see between 18-20 patients per day depending upon the procedures he was doing. If the patient received manipulation this amount would decrease. By December of 2012, he was doing up to 15 procedures per day twice per week. We ceased doing anything in the center as of Jan. 2013. We had to start again slowly in May of 2013, all over again. Based on what little historical data we had and with the amount of new patients we see, we estimated the numbers contained in the application.

Please explain what you mean by anecdotal information from physicians. Please give some specific examples.

We used the term "anecdotal information" to refer to information received by word of mouth, as opposed to some national or local study. The projections we made in the application were based on what our physicians, including our anesthesiologist, told us about the patients they were seeing. An example is given immediately above (the prior question/answer).

Of these procedures how many are based on historical utilization and how many from anecdotal information from doctors in the Nashville area.

Historically, we know we are able to do twenty procedures per day at maximum and we were averaging approximately 15 per day with the history we had.

In addition, please clarify if the mentioned Nashville doctors have verbally committed or have provided letters stating they will refer to the proposed project.

The doctors who currently refer to us do so for pain management services, which would include any treatment decided by a pain management facility. All referring physicians receive a letter describing what type of treatment their patient is getting.

7. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (4) Need and Economic Efficiencies

Please address the following statement as related to this proposal:

"A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above."

According to the latest JAR information (2012, Provisional), the four ASTCs which limit their procedures to pain management averaged 2,359 procedures per room (see Attachment C.N.5.B). This amount (2,359) is over 26% higher than the stated Guideline amount of 1,867 cases per room. The current utilization amount is, therefore, 126% utilization – well above the 70% utilization suggested by this Guideline.

8. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (6) Other Standards and Criteria

Please provide documentation that a majority of patients reside within 60 minutes average drive time to the applicant's facility.

According to the official TN Department of Transportation State Map, it is 18 miles from Nashville to Franklin, 28 miles from Nashville to Murfreesboro, and 28 miles from Nashville to Springfield (the county seats were used for each of the four counties in our service area, since such cities are centrally located in each county). According to MAPQUEST, it takes about 28 minutes to drive from Nashville to Franklin, about 38 minutes to drive from Nashville to Murfreesboro, and about 37 minutes to drive from Nashville to Springfield. Therefore, the majority of patients in these four counties should be able to arrive at the Applicant's site within 60 minutes drive time.

9. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (9) Other Standards and Criteria

Please clearly state the specific methodology and assumptions by which the utilization for the first 8 quarters was projected.

Tennessee Spine and Nerve Institute currently sees between 150 and 200 new patients per month. According to our pain anesthesiologist approximately 80 percent of those patients are a candidate for interventional procedures for pain. He estimates two procedures/cases per patient in a given year. Using 150 patients as our base, that equates to 1,800 patients times 80% or 1440 receiving procedures x 2 cases, or 2880 total cases per year. If we saw 200 new patients per month then the math would be 2,400 new patients times 80 percent which equals 1,920 patients times two cases equals 3,840 cases per year. We anticipate increasing our new patient referrals as we are able to do more services. At 4,442 cases, we are approaching the maximum one pain physician can do in our center and will have to hire another physician.

As for our quarterly assumptions, we simply divided the projected number of annual procedures by 4 and reported that number. Any manner of projecting how many procedures, by quarter for 8 successive quarters, would be speculative. As we have some history of providing the service, we made the logical assumption that there would not be so much of a "ramping-up" time frame for this service.

10. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (10) Other Standards and Criteria

Please list the physicians that will provide pain intervention services in the proposed ASTC and their qualifications/certification/specialties.

Jay Parekh, DO. Anesthesiologist, Boarded in Pain Medicine

Please identify the Medical Director and his/her qualifications.

Co-Medical Directors-Jay Parekh, DO, Anesthesiologist, Boarded in Pain Medicine. Melvin Butler, MD, Boarded in Internal Medicine, and Gastroenterology

Please address question 10 (b).

We anticipate the existing physicians, listed above and below, will continue to utilize the ASTC. As stated, our ASTC is licensed and accredited by AAAHC. As such, we have sufficient staff to add this type of service, and no additional staff will be needed.

Please identify the four physicians that have used the existing ASTC.

There were really five physicians, as follows:

James Ladson, MD-Anesthesiologist, Fellowship in Pain Medicine.
Jay Parekh, DO-Anesthesiologist, Boarded in Pain Medicine.
Michael Skaredoff, MD-Anesthesiologist, Boarded in Pain Medicine.
Lance Benedict, DC-Chiropractor.
Terry Totty, DC-Chiropractor.

Please document that the applicant has a contract for anesthesiology services.

MUA of Middle Tennessee has an anesthesiology agreement with Sweet Dreams Anesthesia, Inc.

Please identify the TennCare MCOs with which the anesthesiology service contracts.

The anesthesiology service we contract with (Sweet Dreams) has contracts with Americhoice, Amerigroup and BlueCare. They also have contracts with all insurers.

11. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (11) Other Standards and Criteria, Access to ASTCs

Please indicate if there are any designated medically underserved areas in the proposed service area as designated by the United States Health Resources and Services Administration.

Yes. Please see *Supplemental Medically Underserved Areas.*

The applicant has listed insurance plans that have contracted with the applicant. Please indicate if the listed insurance companies will contract with the applicant for interventional pain management services.

Yes, the listed insurance companies will contract with MUA of Middle Tennessee for interventional pain management procedures.

12. Section C, Need, Item 3.

Please provide the projected number and percentage of patients by county of residence.

The following Year 1 approximations are based on historic patient origin for the Applicant owners:

County	# Pts	% Pts
Davidson County	1,040	30.1%
Robertson County	686	19.8%
Rutherford County	697	20.2%
Williamson County	1,032	29.9%

It is important for the reviewer to understand that we projected seeing 3,455 patients in Year 1. This projection was based on fact that about 98% of our existing patients originated from the 4 county service area. However, the above numbers represent 100% of the projected 3,455 patients, and the 3,455 patients represents about 98% of the applicant's current case load.

13. Section C, Need, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	Davidson	Robertson	Rutherford	Williamson	Service Area	TN
2013 Age 65+	72,486	8,329	24,822	18,589	124,226	904,587
2015 Age 65+	76,318	8,991	27,598	20,689	133,596	960,158
Age 65+, % Change	5.3%	7.9%	11.2%	11.3%	7.5%	6.1%
2015 Age 65+, % Total	12.4%	12.5%	10.2%	10.5%	11.6%	14.7%
2013 Total Pop.	605,923	69,680	261,331	188,259	1,125,193	6,414,297
2015 Total Pop.	614,222	72,006	271,112	196,824	1,154,164	6,530,459
Total Pop. % Change	1.4%	3.3%	3.7%	4.5%	2.6%	1.8%
TennCare Enrollees 2012	119,510	11,452	36,715	8,690	176,367	1,206,538
TennCare Enrollees as a % of Total Pop.	19.7%	16.4%	14.0%	4.6%	15.7%	18.8%
Median Age	33.9	37.6	32.2	38.5	N/A	41.3
Median Household Income 2007-2011	$46,737	$50,759	$54,433	$89,063	$240,992	$43,989
Below Poverty Level % 2007-2011	17.7%	13.2%	12.7%	5.5%	N/A	16.9%

14. Section C, Need Item 5

Please indicate if there are unimplemented CONs of similar institutions in the service area.

There are none, to our knowledge.

The chart in Attachment C.N.5.C is noted. For comparative purposes, please compare the anticipated charges by the applicant to the 4 listed ASTC's.

The last three years of JAR data in attachments C.N.5.B. and C.N.5.C includes 2012 provisional data. Please also include final 2009 Joint Annual Report data in those charts.

Please see *Supplemental C.N.5.B*, which shows requested 2009 utilization data for all ASTCs in the service area, *and Supplemental C.N.5.C*, which has the additionally-requested 2009 financial data.

The 2012 Gross and Net Charges per procedure of existing ASTCs were $1,261 and $440, respectively. Comparable figures for Year 1 for the Applicant are $1,345 and $269, respectively.

15. Section C, Economic Feasibility, Project Costs Chart

What type of moveable equipment does the applicant intend to purchase?

None. We already have an existing used C-Arm, which cost us approximately $60,000, and we utilized that equipment when we were providing the service under our prior approval by the HSDA. We included that historical cost in this application so as not to imply there were no historic costs associated with this service. In fact, there are no more costs associated with this project, and no more equipment will be purchased.

Please indicate if the applicant already has fluoroscopic equipment for injections. If not, does the applicant intend to purchase fluoroscopic equipment?

We do have a fluoroscope.

16. Economic Feasibility, Item 2, Project Funding

Please provide documentation from the Chief Financial Officer of adequate cash reserves to pay for project costs.

As stated, our ASTC is already licensed, and no renovation is necessary to add this service. In addition, all equipment needed is already purchased and in place (as we had been performing these procedures with prior HSDA approval). All costs associated with this project are administrative, only, and have already been paid. No more cash is needed to pay for this project.

17. **Economic Feasibility, Item 4, Historical Data Chart and Projected Data Chart**

Please clarify the period of time interventional pain management services were provided by the applicant as mentioned in this section.

Our pain anesthesiologist performed interventional joint injections from Sept. of 2012 through Dec. of 2012, again starting in May of 2013 through the present.

A Medical Director is listed as an expense of $337,500 per year in the interventional pain management proposed project and in the total facility Projected Data Chart. Since the amount is the same on both, does this mean the physician will devote all his time to interventional pain management?

This was an estimate on the cost of having co-medical directors, one of whom would perform the interventional procedures.

Please clarify if $125,000 in salaries and wages will cover all full time employees associated with this project.

Yes, it will, not counting the pain physician.

Why is rent in Year 1 in the amount of $40,380 for the proposed interventional pain management project higher than rent in the amount of $39,633 in Year 1 for the whole facility on the Projected Data Charts?

There are CAM charges that vary from year to year. We included them in the rent for year 1 in the interventional pain management project. After this year, we have a more accurate accounting of what the fees will be.

Why is depreciation and rent the same amount on the Projected Data Chart for Interventional Pain Management and the Projected Data Chart for the whole facility?

Our ASTC is already licensed. We are only adding a service with this application. Rent and Depreciation will remain the same, whether or not this application is approved.

There appears to be calculation errors in the amount of operating expenses in Year One and Year Two on the Projected Data Chart for the total facility. Please correct and resubmit a replacement page.

Please see replacement page 29-R.

Is it reasonable to expect to be able to hire an ASTC administrator for $12-15K?

The administrator will be shared with Tennessee Spine and Nerve institute, and this amount is the "share" to administrate the ASTC.

18. Section C., Economic Feasibility, Item 10

The applicant balance sheet reflects a current ratio of .86:1 and $13,735 in cash. Please verify the applicant has adequate cash to meet short term obligations.

The current facility is meeting all of its financial obligations, and will be no additional financial increases by obtaining a CON for interventional pain management procedures.

19. Section C, Economic Feasibility, Item 6.B

Please indicate the top 10 projected CPT reimbursed procedures for this proposed project.

CPT Code	Brief Description
63650	Dorsal column nerve stimulator
64555	Peripheral Nerve Neurostimulator
64635	Radiofrequency ablation-destruction of nerve by neurolysis lumbar one level
64633	Radiofrequency ablation-destruction of nerve by neurolysis-cervical one level
62311	Epidural steroid injection lumbar
62310	Epidural steroid injection cervical or thoracic
64493	Facet Injection Lumbar one level
64490	Facet injection cervical one level
64494	Facet injection lumbar second level
64491	Facet injection cervical second level.

20. Section C, Orderly Development, Item 2

Please identify the 4 ASTCs the applicant mentions in this section that appear to limit their services to interventional pain management services.

These are the four ASTCs listed in the original application (Attachment C.N.5.C) which list 100% interventional pain management services. They are: Premier Radiology Pain Management, St. Thomas Outpatient Neurosurgical, Tennessee Pain Surgery, and Crossroads Surgery.

21. Section C, Orderly Development, Item 3

Please provide the anticipated staffing pattern for the proposed project. Also, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor and Workforce Development and/or other documented sources.

We will use the following support staff: RN, MA/Receptionist, RT (Radiology Tech). We pay our RN $34/hr and the prevailing wage pattern is approximately $31/hr. We pay our MA $13/hour and the prevailing wage pattern is approximately $13.80. We pay our RT $24/hr and the prevailing wage pattern is approximately $23.50. No additional staff is required for the addition of this service. As for FTEs, we will utilize our existing 1 RN FTE, 1 MA/Receptionist FTE, and 1 RT FTE, and all of these existing staff will continue to be "shared" with other functions approved for our ASTC.

22. Section C, Orderly Development, Item 7

The applicant will seek accreditation through AAAHC. Please clarify if this certification applies to Intervention Pain Management Procedures.

We have already received certification from AAAHC for Interventional Pain Management Services. During their extensive two-day process, they observed our pain anesthesiologist performing interventional procedures and participating in manipulation under anesthesia.

23. Project Completion Forecast Chart

The agency decision date appears to be incorrect. Please revise and resubmit the Project Completion Forecast Chart.

Please see replacement page 41-R.

Service Area ASTC's
Pain Management

2009	Co.	ORs	PRs	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,152	7,680	15.0%	2,149	16,670	12.9%	2,381
Baptist Plaza Surgicare	Davidson	9	1	10	1,109	9,922	11.2%	3,436	24,153	14.2%	2,415
Centennial Surgery Ctr	Davidson	6	2	8	564	3,633	15.5%	2,415	13,471	17.9%	1,684
Northridge Surgery Ctr	Davidson	4	1	5	836	3,789	22.1%	2,201	11,202	19.6%	2,240
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	248	2,425	10.2%	638	5,317	12.0%	2,659
Premier Radiology Pain Management Ctr	Davidson	0	2	2	4,156	4,156	100.0%	4,984	4,984	100.0%	2,492
St. Thomas Campus Surgicare	Davidson	6	1	7	1,676	8,028	20.9%	4,007	18,361	21.8%	2,623
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	2	4	2,197	2,197	100.0%	4,539	4,539	100.0%	1,135
Summit Surgery Ctr	Davidson	5	1	6	2,256	7,279	31.0%	4,470	13,897	32.2%	2,316
Tennessee Pain Surgery Ctr	Davidson	1	3	4	8,685	8,685	100.0%	24,956	24,956	100.0%	6,239
Middle Tennessee ASTC	Rutherford	6	1	7	280	5,385	5.2%	775	10,758	7.2%	1,537
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	819	3,651	22.4%	1,889	7,754	24.4%	1,551
Surgicenter of Murfreesboro Med. Clinic	Rutherford	4	3	7	0	7,263	0.0%	0	9,027	0.0%	1,290
Cool Springs Surgery Ctr	Williamson	5	1	6	692	6,751	10.3%	1,309	10,491	12.5%	1,749
Crossroads Surgery Ctr	Williamson	*	*	*	*	*	*	*	*	*	*
Williamson Surgery Ctr	Williamson	4	3	7	13	3,680	0.4%	16	6,211	0.3%	887
Total		64	23	87	24,683	84,524	29.2%	57,784	181,791	31.8%	2,090

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
PM Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2009 JAR, Schedule D - Availability and Utilization of Service

Service Area ASTC's
Pain Management Charges

2009	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$5,191,138	$3,611,971	4,156	$1,249	$869	4,984	$1,042	$725
St. Thomas Outpatient Neurosurgical	Davidson	$4,915,738	$2,722,359	2,197	$2,237	$1,239	4,539	$1,083	$600
Tennessee Pain Surgery	Davidson	$17,061,613	$12,992,818	8,685	$1,964	$1,496	24,956	$684	$521
Crossroads Surgery	Williamson	*	*	*	*	*	*	*	*
Total		$27,168,489	$19,327,148	15,038	$1,807	$1,285	34,479	$788	$561

2010	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,179,983	$2,163,383	1,666	$1,909	$1,299	2,751	$1,156	$786
St. Thomas Outpatient Neurosurgical	Davidson	$5,849,686	$2,615,321	2,523	$2,319	$1,037	2,523	$2,319	$1,037
Tennessee Pain Surgery	Davidson	$14,277,365	$3,072,102	2,305	$6,194	$1,333	7,294	$1,957	$421
Crossroads Surgery	Williamson	$590,000	$207,350	220	$2,682	$943	500	$1,180	$415
Total		$23,897,034	$8,058,156	6,714	$3,559	$1,200	13,068	$1,829	$617

2011	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,680,792	$1,184,882	$2,000	$1,840	$592	3,282	$1,122	$361
St. Thomas Outpatient Neurosurgical	Davidson	$5,811,928	$2,473,977	$2,469	$2,354	$1,002	5,544	$1,048	$446
Tennessee Pain Surgery	Davidson	$13,137,957	$5,378,167	$3,316	$3,962	$1,622	7,848	$1,674	$685
Crossroads Surgery	Williamson	$331,500	$103,089	$116	$2,858	$889	1,560	$213	$66
Total		$22,962,177	$9,140,115	$7,901	$2,906	$1,157	18,234	$1,259	$501

2012 - Provisional	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$6,171,671	$1,520,976	1,957	$3,154	$777	3,196	$1,931	$476
St. Thomas Outpatient Neurosurgical	Davidson	$5,457,807	$2,291,681	2,530	$2,157	$906	5,465	$999	$419
Tennessee Pain Surgery	Davidson	$14,637,835	$5,604,720	2,847	$5,141	$1,969	8,960	$1,634	$626
Crossroads Surgery	Williamson	$1,518,879	$286,422	432	$3,516	$663	4,419	$344	$65
Total		$27,786,192	$9,703,799	7,766	$3,578	$1,250	22,040	$1,261	$440

Source: 2009,2010,2012 & 2012(Provisional) JAR, Schedule D - Availability and Utilization of Service & Schedule F - Finacial Data

* No JAR

PROJECTED DATA CHART
(Total Facility)

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

		Yr-1	Yr-2
A.	Utilization/Occupancy Rate *(surgical patients))*	3,605	4,627
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services	6,896,975	8,749,490
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**6,896,975**	**8,749,490**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	4,896,852	6,212,137
	2. Provision for Charity Care	356,098	451,349
	3. Provision for Bad Debt	298,379	377,779
	Total Deductions	**5,551,329**	**7,041,265**
	NET OPERATING REVENUE	**1,345,646**	**1,708,225**
D.	Operating Expenses		
	1. Salaries and Wages	125,000	128,750
	2. Physician's Salaries and Wages (Medical Director)	337,500	357,750
	3. Supplies	148,000	169,533
	4. Taxes	25,800	34,533
	5. Depreciation	11,316	11,316
	6. Rent	39,633	40,380
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses (Specify) office supplies, advertising, insurance, utilities	138,800	138,800
	Total Operating Expenses	**826,049**	**881,062**
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	**519,597**	**827,163**
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**519,597**	**827,163**

PROJECT COMPLETION FORECAST CHART

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 12/2013.

Assuming the CON approval becomes the final agency action on that date; indicate the number of day **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy (renovation)		
10. *Issuance of license	60	02/2014
11. *Initiation of service	60	02/2014
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

*** For projects that do NOT involve construction or renovation : Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

0101675196

Affidavit of Publications

SEP 30 AM 11:18

3298

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

Newspaper: THE TENNESSEAN

State Of Tennessee

TEAR SHEET ATTACHED

Account Number: 496359
Advertiser: E GRAHAM BAKER, JR.

RE: MAU OF MIDDLE TN - NOI

I, J Lang **Sales Assistant** for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

8/10/2013 J Lang

Subscribed and sworn to me this 14 day of Aug, 2013

Lola Bates

NOTARY PUBLIC

2013 AUG 8 PM 1 41

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the *Tennessean* which is a newspaper of general
(Name of Newspaper)

circulation in Davidson County, Tennessee, on or before August 10, 2013 for one day.
(County) (Month / day) (Year)

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205, owned and managed by itself, intends to file an application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $200,000.00.

The anticipated date of filing the application is: August 15, 2013.

The contact person for this project is E. Graham Baker, Jr., Attorney
(Contact Name) (Title)

who may be reached at: his office located at 2021 Richard Jones Rd. Suite 350
(Company Name) (Address)

Nashville TN 37215 615 /370-3380
(City) (State) (Zip Code) (Area Code / Phone Number)

E. Graham Baker, Jr. August 08, 2013 graham@grahambaker.net
(Signature) (Date) (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Frost Building
161 Rosa L. Parks Blvd., 3rd Floor
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

* The project description must address the following factors:

1. General project description, including services to be provided or affected.
2. Location of facility: street address, and city/town.
3. Total number of beds affected, licensure proposed for such beds, and intended uses.

WEEKS & ANDERSON
An Association of Attorneys

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NASHVILLE, TENNESSEE 37215-2874
TELEPHONE 615/383-3332
FACSIMILE 615/383-3480

KENT M. WEEKS
ROBERT A. ANDERSON

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

DIRECT TELEPHONE NUMBER: 615/370-3380

January 9, 2014

Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Re: Certificate of Need Application (CN1308-031)
MUA of Middle Tennessee, LLC

Dear Melanie:

Please find attached letters of support for the reference project.

Respectfully,

E. Graham Baker, Jr.
/mp

JOE ARMSTRONG
State Representative
15th Legislative District

PO BOX 6597
Knoxville, TN 37914

LEGISLATIVE OFFICE
35 Legislative Plaza
Nashville, TN 37243-0115
Phone: (615) 741-0768
Fax: (615) 253-0316
rep.joe.armstrong@capitol.tn.gov

House of Representatives
State of Tennessee

President
National Black Caucus of State Legislators

MEMBER of COMMITTEES

Finance, Ways and Means
Transportation
Sub of Finance, Ways and Means

December 30, 2013

Melanie Hill, Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

Re: CON Support
Smoky Mountain Ambulatory Surgery Center - Knoxville
Tennessee Spine and Nerve Institute - Nashville
Request for Interventional Pain Management Procedures

Dear Ms. Hill:

As discussed in the meeting earlier this year, I am concerned with the procedures taken by your office in regard to the Smoky Mountain Ambulatory Surgery Center in Knoxville and the Tennessee Spine and Nerve Institute in Nashville.

The lack of accessible surgical referral sites for some of our indigent and elderly patients poses a great health risk. Locations such as the Smoky Mountain Ambulatory Surgery Centers serve as alternatives to meet the needs of our community and our patients.

Our communities need more Ambulatory Care locations serving patients with interventional pain management procedures. Having access to Smoky Mountain Ambulatory Surgery Center with providers, who are familiar with performing procedures, is an improvement in the quality of care. Increasing the services of Smoky Mountain Ambulatory Surgery Center to include interventional pain procedures, will allow a comprehensive approach to pain management not based on medications.

I strongly support the Smoky Mountain Ambulatory Surgery Centers and I ask that you please grant their request for inclusion of interventional pain procedures as part of their services.

Sincerely,

Joe Armstrong

State Representative Joe Armstrong

PREMIER ORTHOPAEDICS
& SPORTS MEDICINE, PLC
Skyline Care Center
3443 Dickerson Pike
Suite 190
Nashville, TN 37207
Telephone (615) 860-1580
Fax (615) 860-1541
www.premier-ortho.com

Steven G. McLaughlin, M.D.
L. Brett Babat, M.D.
Steve G. Salyers, M.D.
Daniel J. Burval, M.D.

Paul A. Abbey, M.D.
Malcom E. Baxter, M.D.
Joseph D. Chenger, M.D.
Robert M. Dimick, M.D.
Brandon H. Downs, M.D.
James W. Eby, M.D.
James M. Fish, D.O.
Jason K. Haslam, M.D.
William J. Jekot, M.D.
Sean B. Kaminsky, M.D.
Melvin D. Law, Jr., M.D.
Jeffrey P. Lawrence, M.D.
Robert W. Lowe III, M.D.
William C. Mayfield, III, M.D.
Daniel J. McHugh, M.D.
Gregg A. Motz, M.D.
Vincent P. Novak, M.D.
Roger N. Passmore, M.D.
V. Douglas Pierce, Jr., M.D.
Michael L. Reid, M.D.
R. James Renfro, Jr., M.D.
Marc A. Tressler, D.O.
Joseph A. Wieck, M.D.

To whom it may concern,

I have been referring patients to Tennessee Spine and Nerve for the past three to four years. My patients and I have been more than impressed by the quality of care they deliver. Their response time is excellent, I have seen no safety issues at all, and I find their communication with me and, more importantly, with the patients I send, to be exemplary. I certainly support their effort to expand MUA of Middle TN to include interventional pain procedures.

Sincerely,

L. Brett Babat, MD

LEGISLATIVE OFFICE:
36 LEGISLATIVE PLAZA
NASHVILLE, TENNESSEE 37243-0167
(615) 741-4410 PHONE
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House of Representatives

State of Tennessee

MEMBER OF COMMITTEES:
FINANCE WAYS & MEANS
FINANCE SUBCOMMITTEE
HEALTH

GARY ODOM
STATE REPRESENTATIVE
55TH LEGISLATIVE DISTRICT
DAVIDSON COUNTY

December 31, 2013

Melanie Hill, Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

Re: CON Support
Smoky Mountain Ambulatory Surgery Center - Knoxville
Tennessee Spine and Nerve Institute - Nashville
Request for Interventional Pain Management Procedures

Dear Ms. Hill,

As I have personally advised you during our meeting earlier this year, I am very concerned about the process that has been followed by your agency with regards to the Smoky Mountain Ambulatory Surgery Center in Knoxville and the Tennessee Spine and Nerve Institute in Nashville. Both of the surgery centers utilize multi-disciplinary physicians including an anesthesiologist, internist, osteopath and chiropractor with support of an on-staff orthopedic surgeon and neurosurgeon in providing the highest quality of care for their patients. It has long been my belief that these types of practices, which have the capability of providing a broad spectrum of care through a multi-disciplinary system of providers, are models for optimum patient care.

My concerns center on the fact that a CON was appropriately issued to each of these surgery centers but once complaints were filed against both surgery centers by a lobbyist for the Tennessee Medical Association and an anesthesiologist in Knoxville your agency unilaterally suspended the CON for both surgery centers. At the time of our meeting earlier this year there were no complaints filed with your agency by patients nor were there any allegations of malpractice or poor outcomes except perhaps by competing interests - not patients of either center. As you will recall, following our meeting, the CONs for both center were reinstated under the condition that there would be full hearings on both CONs sometime in the future. It is clear that the reinstatement

of the CONs is an admission that you had no evidence of malpractice or even poor patient outcomes from either center. It is just as clear that this unprecedented process was initiated by competing interests including the Tennessee Medical Association. In addition, I have seen copies of emails from a Nashville anesthesiologist associated with a large group practice of anesthesiologists urging his colleagues not to do business with a medical supply company that provides equipment and supplies to the two centers that have been subjected to this "witch hunt." These actions constitute clear evidence of anti-trust and/or anti-competitive activities. For this reason, I have initiated a request for investigation by the Federal Trade Commission.

Throughout my legislative service I have always supported the certificate of need process. I have done so in order to protect the larger interest of our citizens because in many cases a CON granted to a surgery center can do great financial damage to small hospitals. Especially hospitals in our rural areas which are already struggling to survive. This damage is accomplished by the center siphoning off a revenue stream from the hospital that is used to help provide emergency and in-patient care. However, this matter is quite different. Once an existing CON for a surgery center, especially in an urban area, can be placed in jeopardy, not because of poor quality care but by competing interests who, in most cases, will not even accept Medicaid patients, I must rethink my position.

These two surgery centers, one of which is located in the district I represent, have suffered significant damage from the actions of your agency. They were literally closed down for several months after you suspended their CON. This resulted in current patients not being able to receive care and as with any small business, the financial impact was devastating to each surgery center. Both surgery centers have been damaged as a result of unhappy competitors who appear to me to be unconcerned about patient care, especially with the Medicaid covered population of citizens, and more concerned about the prospect of patients being driven to their own offices by government edict. This is not the way our health care delivery system should function and I urge you to stop persecuting these two surgery centers and take whatever action is necessary to allow them to continue providing care for my constituents in Nashville and those in the Knoxville area who wish to continue receiving their care from the provider of their choice. I look forward to your response.

Respectfully

Gary Odom
State Representative
55th District

JAMES R. HEAD, M.D.
394 Harding Place #102
Nashville, TN 37211
Office: 615-834-3123
Fax: 615-834-3008

To Whom It May Concern,

I am in support of MUA of Middle Tennessee expanding their services to include all interventional pain procedures. Patient accessibility is increased by having the convenience of a surgery center contiguous with the pain management office. Using dedicated, trained staff increases quality of care for chronic pain patients.

Sincerely,

James R. Head, M.D.

SOUTHSTREET FAMILY MEDICAL CENTER, INC
901 12TH AVENUE, SOUTH
NASHVILLE, TENNESSEE 37203
PHONE: 615-254-1786 *FAX: 615-726-2961*
southstreet901@aol.com
S L LAMPKIN, IV, M.D.

07/29/13

To whom it may concern,

I wish this letter to serve as one of support for Tennessee Spine and Nerve to expand services of their surgery center, MTU of Middle Tennessee, to include interventional pain procedures. I am a referring physician to chronic pain management and they do it correctly. This would help patients decrease narcotic use.

Sincerely,

S L Lampkin, IV, MD
Southstreet Family Medical Center

TRI STAR MEDICAL GROUP

Family Practice Associatesof Southern Hills
397 Wallace Road, Building. C, Suite. 100
Nashville, TN 37211
phone: 615-834-6166
fax: 615-781-9755
TriStarMedGroup.com

George L. Holmes, III, M.D.
Robert G. Bishop, Jr., M.D.
Matthew L. Brust, M.D.
Steven P. Johnson, M.D.
Kathryn Fordham, FNP-BC
Jeffrey Greene, MD
Christopher D. Holloway, M.D.
Daniel Hartman, D.O.
Keren Holmes, M.D.
Jonathan Lee, FNP-C
Kelly Odum, FNP-C
Lori Weber, FNP-C

July 26, 2013

To Whom It May Concern,

Please let this letter serve as a position of support for Tennessee Spine and Nerve to expand the services of their surgery center, MUA of Middle Tennessee, to include all interventional pain procedures. Patients are better served in a safe, quality controlled environment where they are familiar with the pain physicians as well as the staff

Sincerely,

Matthew L. Brust M.D.

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
OFFICE OF HEALTH STATISTICS
615-741-1954

DATE: November 28, 2013

APPLICANT: MUA of Middle Tennessee, LLC
28 White Bridge Road, #210
Nashville, Tennessee 37205

CON #: CN1308-031

CONTACT PERSON: E. Graham Baker, Jr., Esquire
2021 Richard Jones Road, Suite 350
Brentwood, Tennessee 37215

COST: $113,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with the *Tennessee State Health Plan* and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, MUA of Middle Tennessee, LLC, located at 28 White Bridge Road, #210, Nashville (Davidson County), Tennessee, owned and managed by itself, seeks Certificate of Need (CON) approval for the addition of interventional pain management services at its single specialty ambulatory surgical treatment center (ASTC). The applicant filed a Certificate of Need (CN1009-045A) which was approved on 12/15/2010 and implemented on 2/13/2013, according to the HSDA website. Additional comments relating to the licensure history of the applicant is contained in the Contribution to Orderly Development Section of this report.

The proposed new service will be located in the existing office building and will utilize the one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project, and no other health services will be initiated or discontinued.

The applicant is owned by five members who are physicians and is member managed. One of the physicians owns a 39% share, two of the physicians own 21.5% shares each, and another physician owns a 12% share, with the fifth physician having a 6% share of MUA of Middle Tennessee.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the *Tennessee State Health Plan.*

NEED:
The applicant's proposed service area is Davidson, Robertson, Rutherford and Williamson counties. The service area for this project is based on the actual patient origin information for two of the members/owners as noted in the current CON application. The *Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 (Final)* for MUA of Middle Tennessee, LLC documents the ASTC served residents of the following counties: Davidson (6), Dickson (1), Hickman (1), Humphreys (1), Montgomery (1) and Rutherford (1). It is noted these represent the period 4/1/2012 to 6/30/2012.

Note to Agency Members: The applicant presented population data based upon the 2008 population projections of the Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics. These were the most current population projections available to the applicant. The 2013 revised population projections represent the latest official population projections.

Service Area Population Projections

County	2013 Population	2017 Population	Per Cent Increase
Davidson	649,507	676,131	4.1%
Robertson	69,336	73,421	5.9%
Rutherford	285,141	320,172	12.3%
Williamson	198,045	218,093	10.1%
Totals	**1,202,029**	**1,287,817**	**7.1%**

Source: *Tennessee Population Projections 2000-2020, July 2013 Revision*
Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics

Based upon the representations provided at the 12/18/2010 HSDA meeting, MUA of Middle Tennessee, LLC CN1009-045A received approval for the "establishment of an ASTC providing only manipulation under anesthesia services" as a single specialty ambulatory surgical treatment center (HSDA website, *Certificate of Need Projects 2000 to Present*, page 42). In order to understand the applicant's current CON request for interventional pain management services and licensure as a multi-specialty ASTC it is necessary to revisit the original application.

According to the application for CN1009-045A, the MUA procedure involves a new type of institution for which there are no comparable facilities in Tennessee with which to compare utilization, or to gather other forms of comparable data. The applicant reports MUA procedures can be performed in an office setting, so long as medical and chiropractic protocols are followed. The applicant states since MUA procedures have been performed since the 1930s, it is assumed that they are being performed, albeit to a limited extent in Tennessee. It was determined by the Office of Health Statistics, there is only one (1) other licensed single specialty ASTC facility in Tennessee dedicated to MUA procedures.

The Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics reviewed the Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 (Final) for MUA of Middle Tennessee, LLC and determined that the applicant did not provide any MUA services in the 2012 JAR reporting period. The applicant was opened on 4/1/2012 and provided eleven (11) interventional pain management procedures to eleven (11) patients/cases during the period 4/1/2012 to 6/30/2012 which represents the last quarter of the JAR's fiscal year reporting period.

The applicant stated in the original application CN1009-045A, that according to the Department of Health, Board for Licensing Healthcare Facilities, such procedures could be performed in a specialized ASTC, limiting procedures to be performed to MUA, only.

The applicant projected at that time it would serve 150 MUA patients in year one and 185 MUA patients in year two of the project. This would represent 150 MUA procedures in year one and 185 MUA procedures in year two of the project. Unfortunately, the applicant did not provide complete utilization statistics for the period 4/1/2012 to 12/31/2012 or any data on its services delivered in 2013.

The current CON application CN1308-031 if approved will allow the applicant to function as a multi-specialty ASTC providing interventional pain management services along with manipulation under anesthesia (MUA) services to residents of the designated service area. Unlike MUA services, interventional pain management services are provided by a number of single specialty ASTCs. The following table documents interventional pain management services performed by single specialty ASTCs in the designated service area.

Note to Agency Members: The Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics verified the applicant's utilization data came from the Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 Provisional which was the most recent data available to the applicant at the time this application was prepared. The Office of Health Statistics utilized the Joint Annual Report of Ambulatory Treatment Centers 2012 Final. There were no differences in the data provided by the applicant and that provided by the Office of Health Statistics.

Single Specialty Pain Management ASTC's, 2012 Final

Facility	ORs	Procedure Rooms	2012 Procedures	2012 Patients*
Premier Radiology Pain Management	0	2	6,327	1,957
St. Thomas Outpatient Neurosurgical	2	1	5,465	2,530
Tennessee Pain Surgery	1	3	8,960	2,847
Crossroads Surgery	0	2	4,419	432
Total	**3**	**8**	**25,171**	**7,766**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 Final,* Tennessee Department of Health, Division of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics. *Unduplicated Patients.

The following table documents the Multi-Specialty ASTCs providing interventional pain management services in the designated service area:

Service Area Multi-Specialty ASTC
Pain Management Utilization, 2012

Facility	ORs	Procedure Rooms	2012 Procedures	2012 Patients
Baptist Ambulatory Surgery Center	6	1	2,485	1,178
Baptist Plaza Surgicare	9	1	691	340
Centennial Surgery Center	6	2	3,430	1,569
Northridge Surgery Center	5	2	652	296
Premier Orthopaedic Surgery Center	2	0	287	143
St. Thomas Campus Surgicare	6	1	3,589	1,624
Summit Surgery Center	5	1	2,313	1,057
Middle Tennessee ASTC	6	1	1,918	597
Physicians Pavilion Surgery Center	4	1	1,861	833
Surgicenter of Murfreesboro Medical Clinic	3	3	1,211	802
ASTC of Cool Springs	5	1	785	370
Total	**57**	**14**	**19,222**	**8,809**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 Final,* Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics. *Unduplicated Patients.

TENNCARE/MEDICARE ACCESS:
The applicant states they are a Medicare (#103G495427) and a TennCare (#1531024) provider. The applicant currently contracts with AmeriGroup and states in Section A, Item 12 in the Supplemental that it negotiating with AmeriChoice to secure a contract to provide interventional pain management services. The applicant also provides a list of insurance carriers it currently contracts with in the CON application in the Specific Criteria for Certificate of Need.

The applicant estimates its future payor mix will be as follows: Medicare 40%; Medicaid 10%; commercial 45% and private pay 5%. These payor mix percentages represent the caseload mix not the revenue mix of the applicant.

The anticipated revenue percentages are calculated by multiplying the case mix percentages by the total gross revenue. The applicant projects based on this methodology that it will receive gross Medicare revenue (not counting contractual adjustments) of $1,858,790 and Medicaid/TennCare gross revenue of $$464,975 (not counting contractual adjustments) in the first year of operation. The Projected Data Chart found on page 28 of the CON application states total

gross revenue from interventional pain management services in year one of the project will be $4,646,975, again from all sources.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are correct based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located in the application on page 23. The total estimated project cost is $113,000 according to the applicant.

The Office of Health Statistics reviewed the Project Costs Chart and the comments made by the applicant on page 9 of the CON application which asserts that there are no other costs, other than administrative for this project. The applicant also states that the equipment is already in place. This appears to conflict with the inclusion of $60,000 for moveable equipment. The Project Costs Chart if this item was deleted would total only $53,000 including the CON filing fee. The applicant also stated this additional amount for equipment was already purchased but was included nonetheless, as noted on page 24 of the application.

Historical Data Chart: The Historical Data Chart can be found on page 27 of the CON application. The Historical Data Chart found on page 27 of the current CON application, states MUA of Middle Tennessee, LLC had zero revenue, expenditures and no net operating income or losses during January thru December 2012 and no YTD revenue, expenditures or net operating income less capital expenditures in 2013.

The applicant reported on the 2012 JAR that it performed 11 procedures on 11 patients during the period 4/1/2012 to 6/30/2012 with $18,000 in gross Medicare revenue and net Medicare revenue of only $480 during the JAR reporting period and was open providing some clinical services, whether MUA or interventional pain management services, at various times during the period 4/1/2012 to the current date. It is also noted the Profit and Loss Statement for the CON applicant reflects that it, on an accrual basis had gross income from services of $779,273. The total income from services, less the $631,643.35 for contractual adjustments, was $147,430.07

Projected Data Chart: The Projected Data Chart is located on page 28 in the CON application. This chart represents only interventional pain management services. The applicant projects 3,455 surgical patients in 2014 and 4,442 surgical patients in 2015 with a gross operating income of $4,646,975 and $5,974,490 in each year respectfully. The projected net operating income will be $657,506 and $741,668 in each year, respectively.

The applicant's average gross charge for interventional pain management services in year one is projected to be $1,345 with an average deduction of $1,076 resulting in an average net charge of $269.

According to the applicant, there were no other alternatives considered other than doing nothing. The applicant believes that a special need exists resulting from overmedicating of patients with painkillers and that indications are that Tennesseans may be receiving too many prescription pain medications.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant has a formal contractual relationship with St. Thomas Hospital in Nashville. The applicant states medical and chiropractic doctors, as appropriate, will be on site when interventional pain management procedures are performed.

The applicant states the approval of this project should not have any material adverse impact on any health care providers in the state. There are no other facilities dedicated to the provision of MUA procedures except the one in Knoxville. The proposed staff includes an administrator, a coordinating clerk, and RN. The anesthesiologist and/or CRNA will bill for services separately as will the physicians. The applicant plans on working with area training programs to allow students to rotate through the facility to complete clinical training requirements. No additional staff will be added to those provided by the applicant as a result of the original CN1009-045A.

The applicant will seek licensure from the Tennessee Department of Health, Board for Licensing Healthcare Facilities as a multi-specialty ASTC providing only MUA and interventional pain management services. The Department of Health, Division of Health Licensure and Regulation-Office of Health Care Facilities conducted an initial program and life safety survey on 2/7/12 followed by an initial program certification survey. The program certification survey took place on 6/12/2012 and the life safety survey took place on 6/13/2012. No deficiencies were cited by the Department of Health. The license as an ASTC limited to MUA services was granted on 2/28/2012 and expires on 2/28/2014.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: State Health Plan.*

AMBULATORY SURGICAL TREATMENT CENTERS

Determination of Need

1. **Need.** The minimum numbers of 884 Cases per Operating Room and 1,867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1,867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to specific type or types should apply for a Specialty ASTC.

   The applicant is seeking CON approval for a multi-specialty ASTC providing interventional pain management services in addition to its MUA services previously approved as CN1009-045A. In year one, the applicant projects 3,455 and 4,442 procedures in year one and in year two respectively.

2. **Need and Economic Efficiencies.** An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

   The applicant estimated the projected cases for years one and two of the project based on the specific criteria contained herein.

3. **Need; Economic Efficiencies; Access.** To determine current utilization and need, an applicant should take into account both the availability and utilization of either: all existing

outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR, all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

There are four single specialty ASTCs located in the applicants service area providing pain management services. They are contained in the following:

Single Specialty Pain Management ASTC's, 2012 Final

Facility	ORs	Procedure Rooms	2012 Procedures	2012 Patients*
Premier Radiology Pain Management	0	2	6,327	1,957
St. Thomas Outpatient Neurosurgical	2	1	5,465	2,530
Tennessee Pain Surgery	1	3	8,960	2,847
Crossroads Surgery	0	2	4,419	432
Total	**3**	**8**	**25,171**	**7,766**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 Final,* Tennessee Department of Health, Division of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics. *Unduplicated Patients.

In addition, there are eleven (11) multi-specialty ASTCs that provide pain management services in the service area:

Service Area Multi-Specialty ASTC
Pain Management Utilization, 2012

Facility	ORs	Procedure Rooms	2012 Procedures	2012 Patients
Baptist Ambulatory Surgery Center	6	1	2,485	1,178
Baptist Plaza Surgicare	9	1	691	340
Centennial Surgery Center	6	2	3,430	1,569
Northridge Surgery Center	5	2	652	296
Premier Orthopaedic Surgery Center	2	0	287	143
St. Thomas Campus Surgicare	6	1	3,589	1,624
Summit Surgery Center	5	1	2,313	1,057
Middle Tennessee ASTC	6	1	1,918	597
Physicians Pavilion Surgery Center	4	1	1,861	833
Surgicenter of Murfreesboro Medical Clinic	3	3	1,211	802
ASTC of Cool Springs	5	1	785	370
Total	**57**	**14**	**19,222**	**8,809**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2012 Final,* Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics. *Unduplicated Patients.

4. **Need and Economic Efficiencies.** An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

The applicant is not adding or replacing the one procedure room that currently exists per the original CON (CN1009-045A) but merely will utilize the same procedure room as currently authorized for MUA services for additional interventional pain management

services. The applicant notes correctly the provisional ASTC JAR data for 2012 for the four single specialty ASTCs devoted to interventional pain management services averaged 2,359 procedures per room. This figure was verified by the Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics based on the final 2012 JAR data for ASTCs. This utilization represents 126% of the criteria which is 1,867, this also exceeds the 70% criteria set forth in the criteria.

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

Note to Agency Members: The Department of Health, Division of Policy, Planning and Assessment cannot at the present time determine the number of cases since this data is not reported in the Joint Annual Report of Ambulatory Surgical Treatment Centers.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

The majority of the population in the service area resides within 30 minutes average driving time to the Nashville location, and 98% of the entire patient population will reside within 60 miles of the facility.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

The applicant notes the facility is located near to interstates and other surface transportation routes. The facility is only 18 miles from residents of Franklin, 28 miles from Murfreesboro and 28 miles from Springfield.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The applicant expects 98% of patients will come from the service area. This is based upon the previous history of the Tennessee Spine and Nerve Institute and the estimate of the pain anesthesiologist as related in its response to this question in the first Supplemental.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The applicant provided data in the original CON application addressing projected patient utilization for the first eight quarters and described its methodology in the first Supplemental in response to question 9 from HSDA staff.

10. Patient Safety and Quality of Care; Health Care Workforce.
a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant's reports its facility was recently surveyed by the AAAHC and was certified as an ASTC meeting its accreditation standards.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

The applicant states Jay Parekh, DO. Anesthesiologist Boarded in Pain Medicine will provide pain management services to its patients. The list of physicians using this facility can be found in the first Supplemental in response to question 10 by the HSDA staff. The applicant also stated that the facility has an anesthesiologist agreement with Sweet Dreams Anesthesia, Inc.

11. Access to ASTCs. In light of Rule 0720-11.01, this lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration.

The applicant provided data sourced from the United States Health Resources Service Administration as a part of the first Supplemental. The service area does not, according to this source, have specific shortages at the present time, based upon our understanding of these reports..

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

The applicant contracts with BlueCare, AmeriGroup, TennCare Select, and numerous other third party payors. The estimated payor mix includes 45% Commercial, 40% Medicare, 10% TennCare/Medicaid, and 5% self-pay. The data cannot be determined to be accurate unless the applicant provides additional clarifying material.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times? The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

According to the applicant, the provision of interventional pain management services would be well within the available capacity of MUA of Middle Tennessee, LLC as the pain procedures average 15 minutes in duration not counting clean-up time between cases.

TIMOTHY HILL
STATE REPRESENTATIVE
3rd LEGISLATIVE DISTRICT

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Calendar and Rules
Business and Utilities
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January 8, 2014

Melanie Hill, Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

Re: CON Support
Smoky Mountain Ambulatory Surgery Center - Knoxville
Tennessee Spine and Nerve Institute - Nashville
Request for Interventional Pain Management Procedures

Dear Mrs. Hill,

I appreciate the CON review process, as we have discussed before. It has come to my attention that Smoky Mountain Ambulatory surgery center in Knoxville and Tennessee Spine and Nerve institute in Nashville are under the review process, based on the conversation we had during last legislative session. I have personally visited both locations and have found the staff to be professional and have a desire to be in compliance with the law. My hope is that they will be reapproved in this CON process, to allow them to serve what I perceive to be an underserved population. As always, I appreciate your work and look forward to the CON board determination.

Thank you,

Timothy Hill

State Representative Timothy Hill